

**U.S. Department of Labor**

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***Issue Date: 30 September 2003***

*In the matter of*  
**James H. Perry**  
Claimant

v.

Case No. 2000-BLA-01066

**Del Rio, Inc.**  
Employer

and

**Director, Office of Workers'**  
**Compensation Programs**  
Party in Interest.

**DECISION AND ORDER ON REMAND**  
***AWARDING BENEFITS***

This case was remanded “for further proceedings consistent with [the] opinion” of the Benefits Review Board in an unpublished Decision and Order on January 28, 2003, which affirmed in part, vacated in part and remanded Administrative Law Judge John C. Holmes’ Decision and Order issued on January 24, 2002.

**Background**

The Claimant, James H. Perry, filed his initial application for benefits on September 7, 1999 (DX 1). An initial finding of entitlement was made by the District Director on June 29, 2000, thereby awarding \$720.90 per month to the Claimant. Thereafter, the Employer, Del Rio, Inc., requested a formal hearing before the Office of Administrative Law Judges. Following a formal hearing held on April 23, 2001, Judge Holmes issued a Decision and Order, dated January 24, 2002, awarding benefits.<sup>1</sup> The Employer thereafter filed a timely appeal with the Benefits Review Board (“BRB”), which subsequently issued a Decision and Order, dated January 28, 2003 (BRB No. 02-0382 BLA), affirming in part and vacating in part Claimant’s award of benefits.

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<sup>1</sup> Judge Holmes found that the evidence established the existence of complicated pneumoconiosis and as a result concluded that Claimant was entitled to invocation of the irrebuttable presumption of totally disabling pneumoconiosis pursuant to 20 C.F.R. § 718.304. Judge Holmes further concluded that, in light of Claimant’s seventeen (17) year history of coal mine employment, Mr. Perry was entitled to the rebuttable presumption that his pneumoconiosis arose out of coal mine employment pursuant to 20 C.F.R. § 718.203(b); therefore, benefits were awarded.

The case was remanded to reconsider all of the x-ray evidence and to provide an adequate discussion of the reasons for crediting and discrediting evidence.

### **Mandate on Remand**

On appeal, the Employer alleged numerous errors, many of which were accepted by the Benefits Review Board. The Board accepted the Employer's contention that Judge Holmes failed to sufficiently discuss the X-ray evidence and give adequate reasons for crediting and discrediting such evidence. As a result, the Board provided that this case must be remanded to reconsider all of the X-ray evidence and to provide an adequate discussion as to the reasons for crediting and discrediting the X-ray evidence (BRB Decision and Order, p. 4 – 5).

The Employer next argued that Judge Holmes erred in finding that the biopsy evidence of record supported a finding of complicated pneumoconiosis. The Board agreed with the Employer's argument that Judge Holmes did not adequately present his reasoning for rejecting the opinions of Drs. Powell, Naeye and Jarboe. In doing, so the Board noted that Judge Holmes' findings appear inconsistent and as a result, the evidence requires further consideration and a more specific analysis (BRB Decision and Order, p. 5 – 6).

Based on the foregoing, the Board vacated Judge Holmes' finding of complicated pneumoconiosis and remanded the case for reconsideration of the evidence regarding the existence of complicated pneumoconiosis pursuant to the standards set forth in the Administrative Procedure Act (APA).

Lastly, because the Board vacated Judge Holmes' finding of complicated pneumoconiosis, the Board provided that the issue of onset date remains unsolved. If the existence of complicated pneumoconiosis is not established on remand, the Board instructed that the administrative law judge must then determine whether entitlement is established pursuant to 20 C.F.R. §§ 725.202 and 718.204 (BRB Decision and Order, p. 7).

### **Discussion**

Except as otherwise vacated by the Benefits Review Board, or modified herein, all of the evidence which was previously discussed in the Decision and Order, issued on December 18, 2001, as partially affirmed by the Benefits Review Board, is incorporated herein. Nevertheless, the points raised in the Benefits Review Board's Decision and Order have been resolved, as set forth below, based upon my review and analysis of all the relevant evidence. The Transcript refers to a deposition of Dr. Baron as CX 1, but apparently it was not proffered and is not part of the record. See TR at 6. The Claimant also submitted a report from Dr. Baron dated May 9, 2000 as part of his post hearing brief. As this document was not formally entered into evidence, I do not choose to evaluate it.<sup>2</sup>

As alluded to above, the Board accepted the Employer's arguments and vacated Judge Holmes' finding of complicated pneumoconiosis. On remand, the Board instructed that I consider all of the X-ray evidence, as well as the biopsy evidence which were the basis of Judge Holmes' finding of complicated pneumoconiosis.

In view of the Board's instructions that the x-ray and biopsy evidence be reconsidered on remand, coupled with the fact that this is my first brush with this matter, I will summarize the

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<sup>2</sup> The Claimant did not submit a request that I do so.

pertinent medical evidence of record, albeit in greater detail than the previous rendition by Judge Holmes.

***X-Ray Interpretations***

<b><i>Exhibit</i></b>	<b><i>Film Date</i></b>	<b><i>Reading Date</i></b>	<b><i>Physician and Qualifications</i></b>	<b><i>Interpretation and Comments</i></b>
DX 11, DX 12	9/4/96	9/5/96	Johnstone .	Supine view. No pulmonary contusion identified.
DX 29 DX 38	9/4/96	5/2/00	Wiot, "B/BCR" <sup>3</sup>	Film is unreadable.
DX 11, DX 12	9/6/96	9/6/96	Gentry	Both lung zones have hazy consolidation, especially on the right.
DX 29 DX 38	9/6/96	5/2/00	Wiot, "B/BCR"	Film is unreadable – portable.
DX 11, DX 12	9/12/96	9/12/96	Miller	Compared with 9/6 film (note scrivener's error on date), some improvement.
DX 11, DX12	9/12/96	9/12/96	Foster	Second X-ray of the day. Questionable infiltrate in right infrahilar region.
DX 29 DX 38	9/12/96	5/2/00	Wiot, "B/BCR"	Film quality 3 – portable.
DX 11, DX 12	9/26/96	9/26/96	Hoffnung	Compared with 9/12 study. "Patchy" density noted that could be atelectasis or infiltrate.
DX 29 DX 38	9/26/96	5/2/00	Wiot, "B/BCR"	Film is unreadable – portable.
DX 11. DX 12	9/28/96	9/28/96	Hoffnung	Interstitial edema with right effusion. Atelectasis is assumed.
DX 11, DX 12	9/29/96	9/29/96	Hoffnung	Increased density in right hemothorax.
DX 11, DX 12	9/30/96	9/30/96	Gentry	Density noted.
DX 11, DX 12	9/30/96	9/30/96	Estes	Second X-ray of the day. Tube was inserted to drain fluid but nothing appreciable was taken. Atelectasis noted on left.

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<sup>3</sup> The abbreviations above are used to designate physician's qualifications: "B" for "B-reader," "BCR" for "Board-certified Radiologist," "BER" for "Board-eligible Radiologist" and "BCP" for "Board-certified Pulmonologist".

<b><i>Exhibit</i></b>	<b><i>Film Date</i></b>	<b><i>Reading Date</i></b>	<b><i>Physician and Qualifications</i></b>	<b><i>Interpretation and Comments</i></b>
DX 29 DX 38	9/30/96	5/2/00	Wiot, "B/BCR"	Film is unreadable – portable.
DX 11, DX 12	10/1/96	10/1/96	Estes	Again notes that although tube was inserted, no fluid was found. Opines that it may be because the tube is not close enough to the site.
DX 11, DX 12	10/2/96	10/2/96	Johnstone	Complete opacification of right hemithorax.
DX 29 DX 38	10/2/96	5/2/00	Wiot, "B/BCR"	Film is unreadable – portable.
DX 11, DX 12	10/3/96	10/3/96	Gentry	Diffuse opacification of right hemithorax
DX 11, DX 12	10/4/96	10/4/96	Johnstone	Opacification of right hemithorax
DX 11, DX 12	10/5/96	10/5/96	Foster	Pleural effusion or density in base of left lung.
DX 29 DX 38	10/5/96	5/2/00	Wiot, "B/BCR"	No evidence of pneumoconiosis. Film quality 3 – portable. Noted: Thoracotomy tube.
DX 11, DX 12	10/6/96	10/6/96	Estes	Soft tissue density in right lung. Some atelectasis in right lung. Tube is also noted.
DX 11, DX 12	10/7/96	10/7/96	Johnstone	Compared with 10/4 study, second tube is noted. "water" is present in right lung and subcutaneous emphysema is also present. Left lung clear.
DX 29 DX 38	10/7/96	5/2/00	Wiot, "B/BCR"	No evidence of pneumoconiosis. Film quality 3 – portable.
DX 11, DX 12	10/8/96	10/8/96	Hutchinson	Compared with 10/7 study, large density remains and subcutaneous emphysema is noted.
DX 11, DX 12	10/9/96	10/9/96	Whisnant	Extensive infiltrate on right lung.
DX 11, DX 12	10/16/96	10/16/96	Gentry	Compared with 10/9 X-ray. "Fairly dense consolidation persists in the right mid zone adjacent to the right lateral chest wall, a finding associated with volume loss in the right lower lobe and pleuroparenchymal scarring/retraction. There is also hazy density along the posterior lateral chest wall in the upper zone. The possibility of a loculated pleural effusion and/or empyema cannot be completely excluded. Further evaluation would be aided by chest CT if clinically indicated."

<b><i>Exhibit</i></b>	<b><i>Film Date</i></b>	<b><i>Reading Date</i></b>	<b><i>Physician and Qualifications</i></b>	<b><i>Interpretation and Comments</i></b>
DX 29 DX 38	10/16/96	5/2/00	Wiot, "B/BCR"	No evidence of pneumoconiosis. Film quality 2 – dark. Noted: Air space linear right wall lung. Formulated effusion in right lung.
DX 11, DX 12	1/14/97	1/14/97	Hoffnung	Significant improvement. Density in right lung has reduced in size. Left lung clear.
DX 29 DX 38	1/14/97	5/2/00	Wiot, "B/BCR"	No evidence of pneumoconiosis. Film quality 2. Noted: Major fissure.
DX 11 DX 12	5/21/98	6/12/98	Westerfield, "B/BCP"	Positive for pneumoconiosis, type p/q, 1/1 profusion, and size A. Film quality 2. Noted: R/O lung cancer. Density in right upper lung field may be neoplasm rather than large pneumoconiotic opacity. Granulomatous disease is also a consideration.
DX 11, DX 12	8/26/98	8/26/98	Hoffnung	Less than optimal inspiration was achieved on the current study resulting in some crowding of bronchovascular markings. When compared to Claimant's 1/14/97 x-ray, Dr. Hoffnung noted that the previously described densities in the right hemithorax are again demonstrated, appearing similar to the prior exam.
DX 29 DX 38	8/26/98	5/2/00	Wiot, "B/BCR"	No evidence of pneumoconiosis. Film quality 2.
DX 11 DX 12 DX 28	9/2/98	9/2/98	Westerfield, "B/BCP"	Positive for pneumoconiosis, type q/p, 1/2 profusion, and size A. Film quality 1. Noted: R/O lung cancer. Compare with prior films. Densities in right upper lobe and right middle lobe, maybe neoplasm rather than pneumoconiosis.
DX 11, DX 12	9/24/98	9/24/98	Miller	Ill defined pulmonary densities noted in right lung.
DX 29 DX 38	9/24/98	5/2/00	Wiot, "B/BCR"	Unreadable – portable.
DX 11, DX 12	9/25/98	9/25/98	Whisnant	Densities in right lung noted.
DX 11, DX 12	9/26/98	9/26/98	Foster	Increasing densities bilaterally.
DX 11, DX 12	9/27/98	9/27/98	Miller	Some improvement. Atelectasis and/or infiltrate noted.
DX 29 DX 38	9/27/98	5/2/00	Wiot, "B/BCR"	Unreadable – overexposed.

<i>Exhibit</i>	<i>Film Date</i>	<i>Reading Date</i>	<i>Physician and Qualifications</i>	<i>Interpretation and Comments</i>
DX 11	12/7/98	12/7/98	Ohriber, "B/BCR"	Positive for pneumoconiosis, type p/s, 1/1 profusion, and size A. Film quality 1. Noted: History from patient indicates recent right thoracotomy for nodules which were (according to patient) silicotic nodules. Suggest comparison with previous chest x-rays.
DX 11	12/18/98	12/18/98	Baron	Infiltrate in right upper lobe and pleural thickening.
DX 11 DX 13 DX 27	1/29/99	1/29/99	Powell, "B"	Positive for pneumoconiosis, type pq/t, 1/1 profusion, and size A. Film quality 1. Noted: Unilateral right pleural scarring consistent with right thoracotomy. Elevated right hemidiaphragm calcification of infection.
DX 17	11/12/99	12/28/99	Sargent, "B/BCP"	No evidence of pneumoconiosis. Film quality 2. Noted: Well defined right upper lobe, 4+ cm opacity. Rule out neoplasm. Need additional studies.
DX 16	11/12/99	11/12/99	Hudson	Positive for pneumoconiosis, type p/q, 1/1 profusion and size B. Noted: Patient describes having open lung biopsy for large opacities noted.
DX 25	12/3/99	12/3/99	Broudy, "B"	Positive for pneumoconiosis, type q/t, 1/1 profusion and size A. Film quality 1.

***Pulmonary Function Tests***

<i>Exhibit</i>	<i>Test Date</i>	<i>Physician</i>	<i>Hgt.</i>	<i>Age</i>	<i>FEV<sub>1</sub></i>	<i>MVV</i>	<i>FVC</i>	<i>Tracings</i>	<i>Coop/Comp</i>
DX 11	10/14/96	Baron	69"	45	2.20	----	2.68	Yes	Good
Post-Bronchodilator					2.35	----	2.73		
<b>Comments:</b> Dr. Byers reviewed the results and noted that Claimant has a moderately severe restrictive ventilatory process with reduction in total lung capacity to 61% predicted. The FEV1/FVC ratios are normal. The flow volume loop is consistent.									
DX 11 DX 13	12/12/96	Baron	69"	45	2.57	----	3.61	Yes	Good
Post-bronchodilator					2.32	----	3.76		
<b>Comments:</b> Test with forced expiration revealed a minimally reduced absolute values with minimal airways obstruction and moderate small airways disease. Post-bronchodilator, the air is declined in functions probably secondary to fatigue. Total lung capacity is normal and there is some air trapping present. The diffusion capacity of carbon monoxide is within normal limits. Compared to test done in the hospital 10/14/96, the present ones have improved. Forced vital capacity is now 3.61 liters vs. 2.68 liters then, and the total lung capacity is 6.9 liters, or 104% of predicted, vs. 4.06 then. <b>Interpretation:</b> Minimal obstructive lung disease; improved since previous test.									
DX 11	12/8/97	Baron	69"	46	2.46	----	3.28	Yes	Good

<i>Exhibit</i>	<i>Test Date</i>	<i>Physician</i>	<i>Hgt.</i>	<i>Age</i>	<i>FEV<sub>1</sub></i>	<i>MVV</i>	<i>FVC</i>	<i>Tracings</i>	<i>Coop/Comp</i>
Post-bronchodilator					2.48	----	3.27		
<b>Comments:</b> Test with forced expiration revealed moderately reduced absolute values with normal FEV1 divided by FVC and moderate small airways disease. There is no improvement post-bronchodilators. The peak flow was particularly poor indicative of either poor effort or some degree of obstruction. Total lung capacity is the lower limits of normal and there is some air trapping present. Compared to tests done 12/12/96, the present FVC is worse at 3.28 liters vs. 3.61 liters then, and the FEV1 is about the same. Total lung capacity is definitely lower, having gone down from 6.93 to 5.65%. <b>Interpretation:</b> (1) restrictive lung disease – mild; and (2) moderate small airways disease.									
DX 12 DX 28	9/2/98	Westerfield	67"	47	2.73	60.00	3.53	Yes	----
Post-bronchodilator					2.60	62.0	3.20		
Comments: Spirometry demonstrates mild restrictive ventilatory dysfunction. There is no improvement in flow rates following administration of inhaled bronchodilator. Diffusing capacity is reduced indicative of loss of effective surface membrane for gas transfer.									
DX 11	12/7/98	Burki	66"	47	2.89	----	3.78	Yes	Good
DX 11 DX 13 DX 27	1/29/99	Powell	67"	47	2.12	----	2.65	Yes	Poor
DX 10	11/12/99	Hudson	67"	48	3.06	57.0	3.92	Yes	Good
DX 25	12/3/99	Broudy	67"	48	2.87	79.0	3.79	Yes	Satisfactory
Post-bronchodilator					3.07	78.0	3.87		
Comments: Spirometry reveals a borderline restrictive defect. There is slight improvement after bronchodilation to the point where the vital capacity and FEV1 are both normal. The patient's effort was satisfactory except for the MVV component where it was suboptimal.									

**Arterial Blood Gas Tests**

<i>Exhibit</i>	<i>Test date</i>	<i>Physician</i>	<i>PCO<sub>2</sub></i>	<i>PO<sub>2</sub></i>	<i>Test type</i>
DX 11, DX 12 DX 27	1/29/99	Powell	43.00	69.00	Resting
DX 15	11/12/99	Hudson	41.70	86.00	Resting
Comments: Ambulates with quad cane. His doctor advised no treadmill.					
DX 25	12/3/99	Broudy	44.80	83.50	Resting
Comments: The study was normal on room air at rest except for elevation of the carboxyhemoglobin indicating continued exposure to smoke. The total hemoglobin is 14.5 grams.					

**Relevant Examination and Medical Reports**

<b>Exhibit</b>	<b>Exam Date</b>	<b>Physician</b>	<b>Report Date</b>
DX 11	9/4/96	Dr. Burt	9/4/96
<p>Dr. Burt's medical report is based on his physical examination arising out of Claimant's admission to Bristol Regional Medical Center on 9/4/96. <b>Comments:</b> Mr. Perry, who works as a coal miner, who today while sitting in the coal mines, was struck in the back and lumbar spine when a large rock fell. Patient did not lose consciousness nor suffer any neurologic deficit; however, he was taken to a local ER where there he was noted to have multiple transverse processes fractures of the lumbar spine as well as pedicle fractures through both L-5. Claimant was subsequently transferred by helicopter to Bristol Regional for evaluation. Skull x-rays from the outside hospital are noted to be normal. Cervical thoracic films here are noted to be normal as well. Lumbar spine x-rays and CT of the lumbar spine demonstrate a traumatic spondylolisthesis with fractures through both L5-S1 facets. He is also noted to have an incomplete fracture of the left L-1 vertebral pedicle and a fracture again incomplete through the right L-2 lamina. The transverse processes of L1-L5 on the right side are all fractured. Transverse processes of L-5 and L-4 on the left side are noted to be fractured. CT of the abdomen is noted to be normal with the exception of a small amount of retroperitoneal hematoma. Chest x-ray is noted to be normal. Physical exam revealed that there is some tenderness of the occipital region with a small amount of soft tissue swelling. Cervical spine is soft, supple, and nontender. His extremities show no clubbing, cyanosis or edema. <b>Assessment:</b> Traumatic spondylolisthesis as previously outlined with multiple lumbar spine fractures. <b>Plan:</b> Admit to the hospital. He will need operative stabilization of the aforementioned traumatic spondylolisthesis.</p>			
DX 11	9/4/96	Dr. Johnstone	9/5/96
<p>Dr. Johnstone's medical report is based on his CT scan performed during Claimant's hospitalization at Bristol Regional Medical Center. <b>Comments:</b> CT images of the abdomen reveal bilateral dependent water density debris within the lungs consistent with congestion. No pneumothorax is identified. There is a moderately large hematoma in the right retroperitoneum associated with some multiple transverse processes fractures there. This extends over a 11 cm span and does not yet displace the right kidney anteriorly. A much smaller left retroperitoneal hematoma is seen at the L4 level related to the transverse process fracture there. CT images of the pelvis showed no intrapelvic abnormalities. <b>Impression:</b> (1) moderately large right retroperitoneal hematoma which does not yet displace the right kidney anteriorly despite its 11 cm to inferior span; (2) demonstration of rib fractures particularly on the right inferiorly which are probably the cause for the bibasilar atelectatic/congestive changes; and (3) no evidence of hepatic, splenic, renal or pancreatic laceration.</p>			
DX 11	9/6/96	Dr. Burt	9/6/96
<p>Dr. Burt's medical report is in the form of an operative note based on the operation Claimant had to stabilize the traumatic spondylolisthesis he suffered. <b>Comments:</b> On 9/4/96, Claimant was struck on the back by a large rock while working at a coal mine. As a result, he suffered immediate back pain and described left lower extremity pain. He was subsequently brought to Bristol Regional Medical Center for a neurosurgical evaluation. His pre-operative work-up included: lumbar spine x-rays and a CT scan through the lumbar spine which demonstrated multiple fractures of transverse processes, as well as a traumatic spondylolisthesis with fractures through the L5-S1 facet joints. Today's procedure was for stabilization of the aforementioned fracture. <b>Pre- and Postoperative Diagnosis:</b> Traumatic spondylolisthesis. <b>Operation:</b> (1) open reduction of traumatic spondylolisthesis; (2) posterior interbody fusion; (3) posterolateral arthrodesis; (4) posterior segmental instrumentation; (5) harvesting of bone morcellized autograft through a separate incision; and (6) allograft structural graft.</p>			

<i>Exhibit</i>	<i>Exam Date</i>	<i>Physician</i>	<i>Report Date</i>
DX 11	9/6/96	Dr. Gentry	9/6/96
Dr. Gentry's medical report is based on a chest x-ray taken during Claimant's hospitalization at Bristol Regional Medical Center. <b>Comments:</b> The comparison films are unavailable. Hazy consolidation has developed diffusely over both lung zones, particularly on the right, suggesting pleural fluid in the posterior pleural spaces and possible atelectasis/pulmonary contusion. Pulmonary vessels are normal. No sign of pneumothorax.			
DX 11	9/12/96	Dr. Foster	9/13/96
Dr. Foster's medical report is based on a chest x-ray taken during Claimant's hospitalization at Bristol Regional Medical Center. <b>Comments:</b> At the time of the x-ray, there were no earlier films to compare. Less than maximum inspiration is present. Questionable infrahilar infiltrate on the right is present. The remainder of the lungs appear clear with some chronic change and old granulomatous disease. <b>Impression:</b> Poor inspiration. Questionable infiltrate in the right infrahilar region. The remainder of the lungs are clear with chronic change.			
DX 11 DX 12	9/12/96	Dr. Miller	9/12/96
Dr. Miller's medical report is based on a chest x-ray taken during Claimant's hospitalization at Bristol Regional Medical Center. <b>Comments:</b> Minimal clearing of the lungs with minimal residual density in the right infrahilar region suggesting atelectasis. No significant pleural effusions. <b>Impression:</b> Interval improvement in aeration of the lungs with residual atelectasis/infiltrate in the right base.			
DX 11 DX 12	9/12/96	Dr. Gentry	9/12/96
Dr. Gentry's medical report is based on a lung scan taken during Claimant's hospitalization at Bristol Regional Medical Center. <b>Comments:</b> The ventilation scan revealed normal ventilation bilaterally with no evidence of significant air trapping or ventilation defect. Perfusion study is also normal showing no evidence of significant perfusions/ventilation mismatch or segmental perfusion defect. <b>Impression:</b> Normal ventilation and perfusion lung scans.			
DX 11	9/26/96	Dr. Hoffnung	9/26/96
Dr. Hoffnung's medical report is based on a chest x-ray taken during Claimant's hospitalization at Bristol Regional Medical Center. <b>Comments:</b> Compared to study on 9/12/96. There has been development of patchy density involving the right lower lung zone. This could represent any combination of atelectasis or infiltrate. No other significant changes.			
DX 11	9/27/96	Dr. Byers	9/27/96
Dr. Byers' medical report is in the form of a consultation note arising out of his physical examination of Mr. Perry during Claimant's hospitalization at Bristol Regional Medical Center. <b>Comments:</b> Patient was admitted on 9/4/96 with a lumbar spine fracture when a large rock fell and stuck the miner in the back. Patient had surgical repair on			

<i>Exhibit</i>	<i>Exam Date</i>	<i>Physician</i>	<i>Report Date</i>
<p>9/6/96 by Dr. Burt. A venous doppler ultrasound of the legs showed deep vein thrombophlebitis involving the left popliteal, inferior popliteal veins, which appeared to be acute, and a Greenfield filter was placed at that time. On the evening of 9/25, patient began having pleuritic chest pain to which a CT scan indicated pulmonary embolus. It was reported that Claimant's past medical history is positive for peptic ulcer disease, and according to his chart, he also has black lung and had smoked since he was 14 years old before he quit in 1981. Claimant's arterial blood gas studies revealed a moderately severe restrictive ventilatory process with reduction in total lung capacity to 61% predicted. The FEV1/FVC ratios are normal and the flow volume is consistent. His lungs, on physical exam revealed that there is heavy splinting on the right side; no rubs were appreciated due to the inability of the patient to take a deep breath. <b>Impression:</b> (1) pulmonary emboli; (2) failure of IVC filter placed on 9/12/96; (3) pleurisy and hemodynamic distress secondary to #1; (4) status post peptic ulcer disease without bleed - remote; (5) status post extreme spinal surgery on 9/6/96; (6) post-op anemia with transfusion of one unit; and (7) increased protime.</p>			
DX 11	9/27/96	Dr. Hutchison	9/27/96
<p>Dr. Hutchison's medical report is based on a CT scan of the chest taken during Claimant's hospitalization at Bristol Regional Medical Center. <b>Comments:</b> This is an abnormal study and is characterized by a large filling defect in the proximal right pulmonary artery with relatively sharply defined margins extending to the right lower lobe pulmonary arteries consistent with a pulmonary embolus. <b>Impression:</b> (1) Large filling defect in the proximal right pulmonary artery with a well defined lobulated margin extending through the right lower lobe consistent with a pulmonary embolus. There is associated volume loss in the right base. Smaller amount of volume loss noted in the left base. (2) Small nodular density noted in the right middle lobe measuring approximately .3 cm in diameter and a small pulmonary nodule cannot be excluded. (3) Minimal right pleural fluid.</p>			
DX 11	9/28/96	Dr. Hoffnung	9/28/96
<p>Dr. Hoffnung's medical report is based on a chest x-ray taken during Claimant's hospitalization at Bristol Regional Medical Center. <b>Comments:</b> Compared to 9/26 study. Since the prior exam, there has been development of a moderate sized right pleural effusion and generalized increased interstitial markings. Atelectasis at the right base is presumed and infiltrate not excluded. Findings are most suggestive of development of interstitial edema with right effusion.</p>			
DX 11	9/29/96	Dr. Hoffnung	9/29/96
<p>Dr. Hoffnung's medical report is based on a chest x-ray taken during Claimant's hospitalization at Bristol Regional Medical Center. <b>Comments:</b> There has been further increase in density of the right hemithorax, due to at least in part to increase in right effusion. Underlying atelectasis is presumed and infiltrate is not excluded. Left lung remains generally clear. No other changes.</p>			
DX 11	9/30/96	Dr. Gentry	9/30/96
<p>Dr. Gentry's medical report is based on a chest x-ray taken during Claimant's hospitalization at Bristol Regional Medical Center. <b>Comments:</b> Chest x-ray is compared to the x-ray taken on 9/29/96. Dense consolidation persist throughout the right hemithorax. The left hemithorax is unchanged.</p>			
DX 11	9/30/96	Dr. Estes	9/30/96

<i>Exhibit</i>	<i>Exam Date</i>	<i>Physician</i>	<i>Report Date</i>
<p>Dr. Estes' medical report is based on a chest x-ray taken during Claimant's hospitalization at Bristol Regional Medical Center. <b>Comments:</b> AP portable upright chest x-ray is compared to a study obtained earlier the same day and showed that since that time right-sided chest drainage tube has been inserted. A large right pleural effusion persists. The patient has developed partial atelectasis of the left lower lobe since earlier today. <b>Conclusion:</b> (1) Insertion of right-sided chest drainage tube. No pneumothorax identified. (2) Persistent large volume of right-sided pleural fluid with no significant change in volume being appreciated pre and post chest tube insertion as of this time. (3) Development of partial atelectasis of the left lower lobe since earlier today.</p>			
DX 11	10/1/96	Dr. Estes	10/1/96
<p>Dr. Estes' medical report is based on a chest x-ray taken during Claimant's hospitalization at Bristol Regional Medical Center. <b>Comments:</b> The portable upright chest x-ray is compared to a portable study obtained the previous day and shows again right sided chest drainage tube in situ. There continues to be a large volume of pleural based density in the right hemithorax. Partial atelectasis of the left lower lobe has improved. <b>Conclusion:</b> (1) Right sided chest drainage tube in situ. No pneumothorax. (2) Persistent large volume of pleural based density in the right hemithorax. It is possible that this may be loculated away from the right sided chest drainage tube. Another consideration would be if this is blood that has clotted to the point it does not move freely out through the chest tube. (3) Improvement in partial atelectasis left lower lobe.</p>			
DX 11	10/2/96	Dr. Johnstone	10/2/96
<p>Dr. Johnstone's medical report is based on a chest x-ray taken during Claimant's hospitalization at Bristol Regional Medical Center. <b>Comments:</b> Comparison study is 10/1/96. Redemonstrated is complete opacification of the right hemithorax with water density material. Right chest tube is satisfactorily positioned. Presumably this represents result of lung collapse and consolidation with probable associated pleural fluid. The left lung is clear. Slight shift of the mediastinum from right to left again in keeping with positive mass effect of the right hemithorax. <b>Impression:</b> (1) Complete opacification of the right hemithorax; and (2) Left lung is clear.</p>			
DX 11	10/3/96	Dr. Gentry	10/3/96
<p>Dr. Gentry's medical report is based on a chest x-ray taken during Claimant's hospitalization at Bristol Regional Medical Center. <b>Comments:</b> Diffuse opacification of the right hemithorax persists. Minimal patchy left perihilar consolidation again noted. No interval change.</p>			
DX 11	10/4/96	Dr. Roberts	10/4/96
<p>Dr. Roberts medical report is in the form of an operative note as a result of the thorascopy with evacuation of thoracic hematoma. <b>Pre/postoperative Diagnosis:</b> (1) status post trauma with pulmonary embolus, right; and (2) right hemothorax. <b>Findings:</b> There was a very contused right lung. There was a large amount of fibrinous exudate at #3; moderate hemorrhagic pulmonary parenchyma secondary most likely to pulmonary emboli.</p>			
DX 11	10/4/96	Dr. Johnstone	10/4/96
<p>Dr. Johnstone's medical report is based on a chest x-ray taken during Claimant's hospitalization at Bristol Regional Medical Center. <b>Comments:</b> Comparison study is 10/3/96. Opacification of the right hemithorax is again noted. Currently configuration is strongly suggestive of a large right pleural or blood collection with secondary compromise in the mediation of the right lung. Right lung remains clear. Right chest tube unchanged. <b>Impression:</b> Change in the configuration of the chest over the past two days.</p>			
DX 11	10/5/96	Dr. Foster	10/5/96

<i>Exhibit</i>	<i>Exam Date</i>	<i>Physician</i>	<i>Report Date</i>
<p>Dr. Foster's medical report is based on a chest x-ray taken during Claimant's hospitalization at Bristol Regional Medical Center. <b>Comments:</b> Comparison study is 10/4/96. The two right chest tubes remain in place. No recurrent or residual pneumothorax identified. There continues to be considerable pleural effusion on the right and loculated effusion is felt to be present in the mid and lower lung zones laterally. Some infiltrate in the right lung cannot be ruled out. There continues to be some increased density in the left base thought to represent some sub-segmental atelectasis. The remainder of the left lung is clear with chronic change.</p>			
DX 11	10/6/96	Dr. Estes	10/6/96
<p>Dr. Estes' medical report is based on a chest x-ray taken during Claimant's hospitalization at Bristol Regional Medical Center. <b>Comments:</b> Comparison study is 10/6/96. Present x-ray showed again right sided chest drainage tubes in situ. Pleural based density is redemonstrated in the right lung. Some atelectasis and/or infiltrate is suspected to be present as well. The left lung is well aerated. <b>Conclusion:</b> (1) Right sided chest drainage tubes in situ. (2) Persistent pleural based soft tissue density in the right hemithorax most likely representing hemithorax with loculation and hematoma formation. (3) Some atelectasis is thought likely to be present in the right lung particularly in the right lower lobe.</p>			
DX 11	10/7/96	Dr. Johnstone	10/7/96
<p>Dr. Johnstone's medical report is based on a chest x-ray taken during Claimant's hospitalization at Bristol Regional Medical Center. <b>Comments:</b> Comparison study is 10/4/96. A second right chest tube has been inserted with significant improvement in the amount of the pleural density present. There continues to be a large pleural water density lesion along the region of the major fissure. This may well represent loculated fluid or blood. Increased subcutaneous emphysema is present following the placement of the second right chest tube. The left lung remains generally clear. <b>Impression:</b> Placement of second right chest tube with reduction in the amount of right pleural effusion/hemorrhage.</p>			
DX 11	10/8/96	Dr. Hutchison	10/8/96
<p>Dr. Hutchison's medical report is based on a chest x-ray taken during Claimant's hospitalization at Bristol Regional Medical Center. <b>Comments:</b> Comparison study is 10/7/96. Diffuse infiltrate of the right lung with concomitant pleural based density laterally in the right mid lung zone does not appear significantly altered from the prior study. The left lung demonstrates good aeration with no residual atelectasis or infiltrates noted. There is no evidence for pleural fluid. Small amount of subcutaneous emphysema noted in the right lateral chest wall. <b>Impression:</b> No appreciable change from 10/7/96.</p>			
DX 11	10/9/96	Dr. Whisnant	10/9/96
<p>Dr. Whisnant's medical report is based on a chest x-ray taken during Claimant's hospitalization at Bristol Regional Medical Center. <b>Comments:</b> There is continued rather extensive infiltrate or lung consolidation throughout the right chest. There is some fluid loculated laterally. Left chest is completely clear. <b>Impression:</b> No significant change from 10/8/96. Continued diffuse right lung densities and fluid.</p>			
DX 11	10/9/96	Dr. Jewell	10/10/96

<i>Exhibit</i>	<i>Exam Date</i>	<i>Physician</i>	<i>Report Date</i>
<p>Dr. Jewell's medical report is in the form of a consultation note arising out his physical examination of Mr. Perry during Claimant's hospitalization at Bristol Regional Medical Center. <b>Comments:</b> Claimant complained of persistent numbness and a radicular type of pain in the right lower extremity since his postsurgical time. He described the pain as a rather sharp, deep pain, particularly felt in the medial thigh, medial knee, medial leg, and medial aspect of his foot. Upon examination, Dr. Jewell noted that the patient has a rather significant hypersensitivity to touch and pressure over the plantar aspect of the foot, medial grade and lateral, over the medial foot itself, and medial ankle and leg. He has a good active motor function, circulation is intact. Dr. Jewell reported that patient's pain pattern seems very compatible with a radicular syndrome – he may have a persistent continuing pain and paresthesias due to the original acute root compression, or to bone fragments or other kind of current compression on the root. Dr. Jewell did not find any evidence of primary local pathology causing his pain, which would be directly related to his leg, foot, or ankle. There is a significant potential that he may not completely</p>			
<p>resolve the pain and paresthesias at all. <b>Impression:</b> (1) chronic radicular syndrome, probably L5 root distribution, right lower extremity; and (2) no evidence of a primary acute pathology relative to the right leg, ankle, or foot.</p>			
DX 11	10/16/96	Dr. Gentry	10/16/96
<p>Dr. Gentry's medical report is based on a chest x-ray taken during Claimant's hospitalization at Bristol Regional Medical Center. <b>Comments:</b> Comparison films are dated 10/9/96. Fairly dense consolidation persists in the right mid zone adjacent to the right lateral chest wall, a finding associated with volume loss in the right lower lobe and pleuroparenchymal scarring/retraction. There is also hazy density along the posterior lateral chest wall in the upper zone. The possibility of a loculated pleural effusion and/or empyema cannot be completely excluded. Further evaluation would be aided by chest CT if clinically indicated.</p>			
DX 11	10/16/96	Dr. Burt	10/16/96
<p>Dr. Burt's medical report is in the form of a Discharge Summary arising out of Claimant's discharge from Bristol Regional Medical Center. <b>Admitting Diagnosis:</b> (1) Multiple lumbar spine fractures; (2) Retropleural hematoma, bilateral hemothorax; and Ileus. <b>Discharge Diagnosis:</b> (1) Multiple lumbar spine fractures; (2) Retropleural hematoma, bilateral hemothorax; (3) Ileus; and (4) Status post pulmonary embolism. <b>Operative Procedures:</b> (1) Posterior lumbar interbody fusion, L-5/S-1, with posterior instrumentation; (2) Greenfield filter placement; (3) Swan-Ganz catheterization; (4) Thoracoscopy; and (5) Chest tube placement. <b>Hospital Course:</b> Mr. Perry was referred to my service after a large rock fell on him while working in the coal mines. At the time of arrival, he was noted to be awake and alert, however, in extreme severe low back pain with dysesthetic pain of bilateral lower extremities. Workup at that time included lumbar spine films and x-rays which demonstrated traumatic spondylolisthesis as well as bilateral transverse processes fractures of all lumbar vertebral bodies as well as several linear nondisplaced laminar fractures. He was also noted to have retropleural hematoma as well as bilateral hemothoraces. He was subsequently taken to surgery, at which time he underwent a posterior lumbar interbody fusion, L-5/S-1, with reduction of the fracture and posterior instrumentation. His postoperative course was complicated by the continuance of the dysesthetic foot pain which approximated an S-1 distribution. This has slowly abated since the time of his surgery, however, he still complains of pain over the ball of the right foot. Postoperatively, he underwent Greenfield filter placement, however, subsequent to that began experiencing right-sided chest pain and it was found that he indeed had a pulmonary embolism in spite of the filter placement. He was subsequently anticoagulated and placed in the ICU. At this time, he is currently ambulatory with a walker, tolerating a regular diet. He remains on his Coumadin. It was offered to Mr. Perry that he receive rehabilitational therapy, however, he wishes to go home.</p>			

<i>Exhibit</i>	<i>Exam Date</i>	<i>Physician</i>	<i>Report Date</i>
DX 11	11/18/96	Dr. Roberts	11/18/96
Dr. Roberts' medical report is in the form of a letter to Dr. Burt as a result of his follow-up examination with Claimant. <b>Comments:</b> Dr. Roberts noted that he performed a thoracoscopy on Claimant while he was in the hospital and decorticated and debrided the clot. According to Dr. Roberts, Claimant appears to be doing well; his lungs appear to be relatively clear; his breath sounds appear to have improved on the right.			
DX 11	11/19/96	Dr. Baron	11/20/96
Dr. Baron's medical report is based on Claimant's chest x-ray. <b>Comments:</b> No evidence of pneumoconiosis. Chest x-ray showed the soft tissue and bony structures to be within normal limits. There was an elevated right hemidiaphragm as seen on the PA film. There was thickening of the pleura anteriorly and the major fissure was also thickened. Otherwise, the x-ray was normal in the lung field area. <b>Impression:</b> (1) restrictive lung disease secondary to pulmonary emboli; (2) deep venous thrombosis right; and (3) residual pain, pleuritic right side.			
DX 11	11/19/96	Dr. Baron	11/20/96
Dr. Baron's medical report is in the form of a letter to Dr. Burt as a result of his follow-up examination with Claimant. <b>Comments:</b> In October 1996, Claimant was released after a mining accident for fractured vertebrae which resulted in him developing pulmonary emboli and restrictive lung disease. Claimant had a total lung capacity of 61% of predicted, which is a moderate decline and most of this of course comes from the right lung, which was affected by the embolus. Claimant gets frustrated when he takes a deep breath and he gets dyspneic on exertion. His back however is still hurting him and limits him to a certain extent. Claimant has recently been in a car accident with harm to himself. His legs still show some swelling of the right calf. Physical exam revealed a healthy appearing white male looking heavier than he had previously. His lungs exhibited decreased breath sounds in the right base and axilla. Chest x-ray, which has been included, shows some residual infiltrate and pleural thickening of the right with an elevated hemidiaphragm. <b>Impression:</b> (1) restrictive lung disease secondary to pulmonary emboli; (2) deep venous thrombosis right; and (3) residual pain, pleuritic right side.			
DX 11	12/12/96	Dr. Baron	12/16/96
Dr. Baron's medical report is based on his physical examination of Claimant, as well as diagnostic testing and a chest x-ray. <b>Comments:</b> Claimant still complained of shortness of breath and that he easily tires. He says he becomes dyspneic after walking 25 to 50 yards. He also has chest pain in his right chest at night and is requiring Oxycontin for this every night. Claimant is sleeping better with the medication. He is still using the cane and the walker. Physical exam reveals a depressed, middle aged white male with a cane. His lungs produced decreased breath sounds over the right base with no wheezing, rhonchi, or rales. The pulmonary functions done failed to show any restrictive diseases, but did show some minimal obstructive disease. Post-bronchodilator there was no improvement, and in fact, a decline which was probably from fatigue. The breathing tests do show improvement since those done 3 months ago. <b>Impression:</b> (1) dyspnea probably secondary to trapped lung, right side; (2) status post pulmonary embolus with hemothorax; (3) depression; and (4) trauma secondary to coal mining accident.			
DX 11	1/14/97	Dr. Greene	1/15/97
Dr. Greene's medical report is based on a Venous Visualization Study that Claimant underwent at Bristol Regional Medical Center. <b>Comments:</b> As a result of a mining accident, patient had thrombophlebitis in the left popliteal, posterior tibial and peroneal vessels with pulmonary embolus. He now has bilateral leg swelling with the right greater than the left and has a Greenfield filter in place. <b>Impression:</b> Continued evidence of fairly extensive thrombophlebitis in the left lower extremity involving the mid and distal superficial femoral, popliteal and posterior tibial veins. No evidence of thrombophlebitis in the right lower extremity.			

<i>Exhibit</i>	<i>Exam Date</i>	<i>Physician</i>	<i>Report Date</i>
DX 11 DX 13	1/14/97	Dr. Hoffnung	1/14/97
Dr. Hoffnung's medical report is based on Claimant's lung scan that was performed at Bristol Regional Medical Center. <b>Comments:</b> Dr. Hoffnung reported that this study demonstrated a ventilation defect in the right mid/upper lung zone corresponding with focus of increased density on chest film. This represents a change from the prior lung scan of 9/12/96. After giving patient 5mCi of Tc MAA, a perfusion defect was revealed in the right lung corresponding with the ventilation abnormality and the findings on plain film, which again represents a change when compared to the prior lung scan. <b>Conclusion:</b> (1) matching ventilation/perfusion defect in the right lung corresponding to chest film abnormality; and (2) quantation in each lung.			
DX 11 DX 13	1/14/97	Dr. Hoffnung	1/14/97
Dr. Hoffnung's medical report is based on Claimant's chest x-ray. <b>Comments:</b> Density in the right upper lobe has decreased significantly in size, and there has been near complete resolution of the pleural reaction. Left lung remains clear. <b>Conclusion:</b> Significant improvement in the right hemithorax since the prior exam consistent with resolving or resolved inflammatory process with residua which may now represent scarring.			
DX 11	1/17/97	Dr. Baron	1/20/97
Dr. Baron's medical report is in the form of a letter addressed to Dr. Burt and is based on his 1/17/97 evaluation of the Claimant. <b>Comments:</b> Dr. Baron reported that the last time he saw Claimant, status post pulmonary embolus and pneumothorax with restrictive lung disease and right chest pain, he felt that Claimant might need a decortication. However, Dr. Baron further reported that he may not need a decortication based on a chest x-ray report and a quantitative lung scan. According to Dr. Baron, normally about 55% of the ventilation comes from the right side and 45% from the left with some variation. On Claimant's right side, he was only 41%, with 59% coming from the left; thus, there is some decrease. However, the right lower lung zone contributes 57% of the total, which is good. A copy of the venous doppler exam showed continued evidence of extensive thrombophlebitis in the lower extremity. Physical exam revealed a healthy appearing, sad white male in no acute distress. <b>Impression:</b> (1) right chest pain secondary to hemothorax; (2) restrictive lung disease – improving; (3) thrombophlebitis; (4) anticoagulation; and (5) depression.			
DX 11	2/24/97	Dr. Baron	2/25/97
Dr. Baron's medical report is in the form of a letter to Dr. Burt as a result of his follow-up examination with Claimant. <b>Comments:</b> Claimant is doing relatively well from a respiratory standpoint. However, he is still somewhat short of breath. He can walk about 100 feet slowly, but still walks with a cane as you know. Dr. Baron will refer him to Dr. Roberts for re-evaluation of his lung situation to see if he feels that he can improve the shortness of breath with a decortication status post hemothorax from pulmonary emboli. Dr. Baron is also going to repeat the venous doppler ultrasound to see if we can image the inferior vena cava filter to see if that is clogged up with clot.			
DX 11 DX 13	3/7/97	Dr. Hutchison	3/7/97

<i>Exhibit</i>	<i>Exam Date</i>	<i>Physician</i>	<i>Report Date</i>
<p>Dr. Hutchison's medical report is based on a CT scan performed at Bristol Regional Medical Center.</p> <p><b>Impression:</b> (1) interval resolution of what appear to be bibasilar atelectasis on the prior study; and (2) soft tissue density in the posterior segment of the right lower lobe has demonstrated moderate improvement; there is a large soft tissue density remaining with intermediate attenuation characteristics measuring approximately 3 cm in its greatest dimension having irregular margins, this most likely represents an area of residual contusion; the possibility of a pre-existing mass cannot be excluded but is felt to be unlikely.</p>			
DX 11	3/10/97	Dr. Roberts	3/10/97
<p>Dr. Roberts' medical report is in the form of a letter to Dr. Baron and is based on his evaluation of Claimant.</p> <p><b>Comments:</b> "In review of the CT scans that were done on 3/7/97, I do not see any specific areas of entrapment of the lung that I think would be benefitted by decortication. Claimant still has some residual contusion in the right upper lobe and posteriorly on the right lower lobe is an area of fibrosis and scarring which I think represents the largest area of his pulmonary infarction and/or pulmonary embolus. Claimant has improved in his breathing to where he is walking a little bit more and after a long discussion with he and his wife, I feel that surgical intervention would not be of benefit to him at this time."</p>			
DX 11	5/7/97	Dr. Baron	5/7/97
<p>Dr. Baron's medical report is in the form of a letter to Dr. Burt as a result of his follow-up examination with Claimant.</p> <p><b>Comments:</b> Claimant is walking with a walker and as you will see in a few weeks, is still hunched over complaining of pain. He is in a work hardening program, but has still not been able to get on the treadmill or on a bike. He is getting heavier and still complains of pleuritic chest pain in the right chest where he had his pulmonary embolus. He is also sore to touch in the right posterior chest. Claimant has headaches daily, night sweats, back pain, and is somewhat emotionally upset easily. He still requires Oxycontin at night or Hydrocodone during the day for the pain. His lungs, on physical exam, revealed a pleural rub in one area in the posterior right axilla, and there is pain on palpation in that general area over the ribs. Otherwise, the lungs are clear. <b>Impression:</b> (1) restrictive lung disease secondary to pulmonary embolus; (2) pleuritic chest pain; (3) back pain; (4) depression; (5) eczema; and (6) deep venous thrombosis. Lastly, Dr. Baron noted that he is going to repeat the ultrasound of Claimant's legs to see if the blood clots have resolved, and if so, we can stop the coumadin he is on.</p>			
DX 11	5/13/97	Dr. Baron	5/13/97
<p>Dr. Baron's medical report is in the form of a chart note and is based on his evaluation of Claimant. <b>Comments:</b> Claimant complained of having a knot behind his right thigh. Currently, he is on coumadin, which has been decreased to 7.5 mgs. every evening. On physical exam, he has a subcu hard nodule about the size of a pea in the right posterior medial thigh just above the knee with ecchymoses surrounding it. He also has eczema on the right leg with one large lesion posteriorly. <b>Impression:</b> (1) blood clot right leg, superficial; and (2) eczema.</p>			
DX 11	7/14/97	Dr. Baron	7/15/97
<p>Dr. Baron's medical report is in the form of a letter to Dr. Burt as a result of his follow-up examination with Claimant. <b>Comments:</b> Claimant complained of some right sided chest pain, which is fairly new and has required him to take some Oxycontin at night. He has been reasonably well maintained with prothrombin times on coumadin. His lungs have decreased breath in the right base and the chest wall exhibits tenderness to palpation of the 5<sup>th</sup> and 6<sup>th</sup> costochondral joints and also the xiphoid process, which reproduces his pain. <b>Impression:</b> (1) costochondritis; (2) phlebitis and status post pulmonary embolus; and (3) anticoagulation.</p>			

<i>Exhibit</i>	<i>Exam Date</i>	<i>Physician</i>	<i>Report Date</i>
DX 11	8/29/97	Dr. Baron	9/2/97
<p>Dr. Baron's medical report is in the form of a letter to Dr. Burt as a result of his follow-up examination with Claimant. <b>Comments:</b> Claimant reported to feeling poorly and had a poor summer with continued back pain and the knowledge that he is disabled. Claimant finally realizes, after you told him on multiple occasions, that he cannot work in the coal mine. Claimant's 8/25/97 ultrasound studies of his legs showed no right DVT and the left leg has only 10% blockage. Physical exam revealed an obese white male. His lungs were clear. <b>Impression:</b> (1) DVT; (2) back pain secondary to trauma; and (3) illiteracy.</p>			
DX 11	9/11/97	Dr. Baron	9/11/97
<p>Dr. Baron's medical report is in the form of a letter to Dr. Burt as a result of his follow-up examination with Claimant. <b>Comments:</b> Dr. Baron noted that Claimant has had a slow improvement since his mining accident and the resulting medical treatment. At the present time, he still walks with a limp and uses a cane. He has dyspnea on exertion and feels that he smothers, especially at night. His pulmonary function tests originally showed a great deal of restrictive lung disease, but more recently, December 12, 1996, they showed that the forced vital capacity was minimally reduced, but the total lung capacity was up to 104% of predicted; whereas previously in the hospital 10/14/96, his total lung capacity was only 61% of predicted. At the present time, I don't think his shortness of breath will improve any further. He has some mild airway obstruction, which may not get any better. I think he has reached maximum medical improvement, but needs ongoing therapy. I am hoping that he does not have recurrence of venous thrombosis in his legs, and if he does so, he will require lifelong coumadin at that point. If you saw this gentleman, you would certainly know that he cannot go back to full duties and cannot walk very far or stand for</p> <p>long periods of time, so certainly he cannot go back to his previous job unless they have a very easy job for him. Because of his illiteracy, he would need to get a great deal of training before he could assume other types of jobs. I cannot say whether he will ever be able to walk any distance again; either because of his shortness of breath or his pain in his back.</p>			
DX 11	9/23/97	Dr. Baron	9/23/97
<p>Dr. Baron's medical report is in the form of a letter to Dr. Burt as a result of his follow-up examination with Claimant. <b>Comments:</b> The repeat of Claimant's ultrasound of his legs proved to be negative except for one popliteal vein. However, he has bilateral edema of his legs, which is new despite being on Triamterine/HCTZ on a daily basis. Claimant stated to Dr. Baron that last week he walked down a hill and his dog had to go get his wife to help him up the hill. His depression is worse than ever. Since gaining weight, his wife has witnessed short apnea periods and he has excessive daytime somnolence, and recently almost got into an accident falling asleep at the wheel. His right pleuritic chest pain continues with deep breaths. Lungs are clear. <b>Impression:</b> (1) edema; (2) status post DVT; (3) depression; and (4) snoring and excessive daytime somnolence, rule out sleep apnea.</p>			
DX 11	11/18/97	Dr. Goldman	11/18/97

<i>Exhibit</i>	<i>Exam Date</i>	<i>Physician</i>	<i>Report Date</i>
<p>Dr. Goldman's medical report is based on his independent medical examination of Claimant, as well as his review of Mr. Perry's extensive medical record and functional capacity evaluation. Additionally, Dr. Goldman reviewed Claimant's medical, social and occupational histories. <b>Comments:</b> Claimant denied the use of cigarettes. Claimant did not describe his duties at work, but did state that his work was hazardous and heavy duty. Claimant stated that he had been at his job for 9 ½ years prior to his injury and would like to return to his regular job when able and prior to his injury, he had missed no significant work. Physical exam revealed that Claimant walks with a slightly antalgic gait, but appears to be antalgic on the right. He is able to heel-walk, but apparently cannot or will not walk on his toes. He squats only very poorly and does not get down very far. His motor strength throughout the lower extremities, with the exception of the extensor hallucis longus, is 5/5 bilaterally. Claimant's Functional Capacity Evaluation is consistent with the presence of symptom magnification. There is no doubt Mr. Perry has had rather significant injury to his low back area. All of his injuries are in the lumbar spine region. On examination, he does have evidence of radiculopathy and obviously, he had loss of motion segment integrity with his injury. As far as any impairment from his pulmonary embolus and restrictive lung disease, I feel it is best left to Dr. Baron to evaluate this with appropriate pulmonary function testing. I do not know that he will have any significant impairment from these. I see nothing from my examination that would preclude Mr. Perry returning to work in the job described in the 10/27/97 letter. This job requires him to walk approximately a mile in a coal seam, with a height ranging between 70 and 85 inches. His lifting would be limited to five pounds and he would be working when the coal mine was not, so there would be no significant exposure to dust. Basically, he would be required to check air and face conditions and record them accordingly. Again, as his pulmonologist has released him for this job, I see nothing in his physical condition in his low back that would keep him from doing this.</p>			
DX 11	12/8/97	Dr. Baron	12/8/97
<p>Dr. Baron's medical report is in the form of a letter to Dr. Burt as a result of his follow-up examination with Claimant. <b>Comments:</b> Claimant stated that his breathing is worse. He has a cough which is non-productive. He has both pain in his chest and shortness of breath. He also has leg cramps and pain in his right leg. Pulmonary function tests show a slight decline in functions since one year ago. <b>Impression:</b> (1) restrictive lung disease with shortness of breath; and (2) back and leg pain.</p>			
DX 11	2/9/98	Dr. Baron	2/9/98
<p>Dr. Baron's medical report is in the form of a letter to Dr. Burt as a result of his follow-up examination with Claimant.</p> <p><b>Comments:</b> At his follow-up, Claimant complained of shortness of breath when he walks 100 yards or more. Dr. Baron noted that, In the past, we have diagnosed restrictive lung disease, but nothing in the way of asthmatic bronchitis. Claimant did not feel well on the day of the visit – he had pain on deep inhalation on the right side and he feels smothered at night and has some night sweats. Claimant still has pain in his back. Physical exam remain unchanged. <b>Impression:</b> (1) dyspnea; (2) back pain; (3) restrictive lung disease secondary to pulmonary embolus; and (4) elevated cholesterol.</p>			
DX 11	4/24/98	Dr. Baron	4/24/98
<p>Dr. Baron's medical report is in the form of a chart note and is based on his evaluation of Claimant. <b>Comments:</b> Claimant still has the same complaints. He had some nausea and just felt poorly with it. He is still short of breath and has pleuritic chest pain on the right. The swelling in the legs are kept down by diuretics. He has lost 10 pounds since his last visit. Physical exam revealed decreased breath sounds in the right axilla especially; however, no rubs or rales, but there was very slight wheezes in the left upper chest on forced expiration with cough. <b>Impression:</b> (1) restrictive lung disease with shortness of breath; (2) pleurisy; (3) back and leg pain; and (4) hypercholesterolemia and hyperlipidemia.</p>			

<i>Exhibit</i>	<i>Exam Date</i>	<i>Physician</i>	<i>Report Date</i>
DX 12	6/9/98	Dr. Templin	6/9/98
<p>Dr. Templin's medical report is based on his physical evaluation of Claimant, as well as his review of Claimant's medical, social and occupational histories and his diagnostic testing. <b>Comments:</b> Claimant complained of chronic low back pain with radiation into the left leg. He also complained of left leg numbness, right foot pain and shortness of breath. Claimant stated that his symptoms are the result of injuries he sustained in a work-related accident. He denied a history of any previous injury to the low back. He further stated that he is unable to return to his previous work position due to both the back pain and the shortness of breath. The symptoms are said to be increased with any prolonged walking, standing, sitting, frequent bending, stooping, kneeling, crouching, crawling, lifting, carrying, and climbing. Mr. Perry also complained of difficulty with sleep together with nightmares. He has become very depressed over his condition and has asked on several occasions for psychiatric evaluation and counseling. Mr. Perry said that, on two occasions, he attempted to obtain his mine certification but was unable to do so. Mr. Perry is unable to read or write. He also is required to use a cane in ambulation outside of the home. He said as long as he is able to catch himself or hold on to something near him, he feels comfortable in walking and ambulating without the cane. On other occasions, he will frequently lose his balance and fall if he is unable to grab onto something for stabilization. Dr. Templin noted that Claimant does not smoke and worked as a coal miner for a total of 26 years. <b>Diagnoses:</b> (1) chronic low back pain; (2) chronic right sided chest wall pain syndrome; (3) history of coccydynia; (4) depression; (5) history of pulmonary embolus; (6) traumatic spondylolisthesis; (7) status-post open reduction of traumatic spondylolisthesis; (8) history of multiple lumbar spine fractures; (9) history of retroperitoneal hematoma; (10) history of bilateral hemothorax; (11) history of multiple transverse process fractures; (12) multiple mild compression fractures; (13) status-post thoracoscopy; (14) status-post Swan-Ganz catheterization; (15) status-post Greenfield filter placement; (16) status-post posterior lumbar interbody fusion at L5-S1 with posterior instrumentation; (17) history of pulmonary embolus; (18) chronic shortness of breath; and (19) possible post-traumatic stress disorder.</p> <p><b>Causation:</b> Within reasonable medical probability, patient's work-related injury, which occurred on 9/4/96, was the cause of his complaints. Furthermore, no part of patient's condition is due to the effects of the natural aging process. Lastly, patient's work did not aggravate or accelerate the effects of the natural aging process. <b>Apportionment:</b> Patient's condition is not due in part of arousal of a pre-existing, dormant, nondisabling condition or congenital abnormality. Patient did not have an active impairment prior to his injury. <b>Restrictions:</b> Patient has described the physical requirements of his usual and customary work activities, which include bending, pushing, pulling, lifting, twisting, turning, climbing and carrying. Restrictions should be placed upon patient's work activities due to the injury and/or its residuals. Patient is unable to return to any activity requiring prolonged standing, walking, frequent bending, stooping, kneeling, crouching, crawling, lifting, climbing and carrying. Lastly, patient does not retain the physical capacity to return to the type of work performed at the time of injury. <b>Plan:</b> (1) Based on Mr. Perry's physical exam, he would be given a 36% permanent partial impairment to the whole man based on the 1994 AMA Guidelines. (2) Mr. Perry is unable to return to any activity requiring prolonged standing, walking, frequent bending, stooping, kneeling, crouching, crawling, lifting, climbing and carrying. He is unable to walk extended distances due to the shortness of breath. With his illiteracy and inability to read and write, I would question his ability to safely be placed in the position of fire boss. (3) Mr. Perry should obtain psychiatric counseling and treatment.</p>			

<i>Exhibit</i>	<i>Exam Date</i>	<i>Physician</i>	<i>Report Date</i>
DX 11	6/19/98	Dr. Baron	6/19/98
Dr. Baron's medical report is in the form of a chart note and is based on his evaluation of Claimant. <b>Comments:</b> Claimant complained of back and chest pain, and has been very short of breath for the past few days. Claimant is wheezing at night, but does not produce any cough or sputum. Claimant brought in a 5/21/98 chest x-ray which was performed by the Dept. of Labor. Dr. Baron noted that this is residual for the most part and goes back to 1996 from his acute hospitalization. However, when compared to the x-ray from 1996, there is a very small nodular infiltrate below the area of the right upper lobe infiltrate which is somewhat worrisome. Upon examination, Dr. Baron reported that Claimant's lungs show slight wheezing on forced expiration with spontaneous cough. <b>Impression:</b> (1) restrictive lung disease; (2) increase triglycerides and cholesterol; (3) question nodule, right upper lobe; and (4) infiltrate scar, chronic, right upper lobe.			
DX 11 DX 13	6/22/98	Dr. Miller	6/22/98
Dr. Miller's medical report is based on Claimant's CT scan which was performed at Bristol Regional Medical Center. <b>Impression:</b> More focal somewhat lobulated soft tissue lesion in the right lung posterolaterally that may have a major component of scar although an associated neoplastic mass should also be considered. Left lung is clear.			
DX 11	8/26/98	Dr. Baron	8/26/98
Dr. Baron's medical report is in the form of a chart note and is based on his evaluation of Claimant. <b>Comments:</b> Claimant stated that he hasn't been doing well; the heat has been difficult for him. He gets light-headed and dizzy. Claimant continues to have pain in the right side of his chest which has gotten a little worse and he is worried about this. Claimant is also anxious about the "spot" on his lung and x-ray today showed it to be the same. CAT scan two months ago showed some suspicious areas in the right upper lobe, although this is probably scar. Physical exam revealed decreased breath sounds in the right base of the lung. Claimant is also tender to touch in several ribs. <b>Impression:</b> (1) right upper lobe lesion, rule out CA; (2) restrictive lung disease; and (3) elevated triglycerides and cholesterol.			
DX 11 DX 13	8/26/98	Dr. Hoffnung	8/26/98
Dr. Hoffnung's medical report is based on Claimant's chest x-ray. <b>Comments:</b> Less than optimal inspiration was achieved on the current study resulting in some crowding of bronchovascular markings. When compared to Claimant's 1/14/97 x-ray, Dr. Hoffnung noted that the previously described densities in the right hemithorax are again demonstrated, appearing similar to the prior exam.			
DX 11	9/2/98	Dr. Westerfield	9/2/98
Dr. Westerfield's medical report is based on his examination of Claimant as well as his review of Claimant's medical, occupational and social histories. Dr. Westerfield also reviewed two of Claimant's chest x-rays and the diagnostic			

<i>Exhibit</i>	<i>Exam Date</i>	<i>Physician</i>	<i>Report Date</i>
<p>testing that Claimant underwent. <b>Comments:</b> Claimant reported short of breath with exertion, which has not inhibited his work activities; however, it was noticeable at work. Claimant is short of breath walking up an incline about 30 yards and must stop. At the time of examination, Claimant was not smoking cigarettes and in fact quit smoking in 1981. Claimant started smoking as a teenager and smoked heavy before he quit. It was noted that Claimant worked 26 years in the coal mines, all underground. He worked until his was injured in a mine accident in September 1996. As a result, Claimant was hospitalized and developed deep vein thrombosis of his legs which led to pulmonary embolism and apparent pulmonary infarction on his right lung. Claimant reported that he bled into his lung and required chest tube drainage; however, he did not have surgical procedure to his lung, but did have blood drained from his lung and had a chest tube for almost two weeks. <b>Impression:</b> (1) History of exposure to coal dust and underground coal mining; (2) Episode of pulmonary embolism; (3) Shortness of breath; and (4) Chronic back pain secondary to injury. <b>Causation:</b> Within reasonable medical probability, patient's disease or condition is related to his work environment. Within reasonable medical probability, any pulmonary impairment is caused in part by factors in patient's work environment (e.g., coal dust, chemicals). <b>Impairment:</b> Patient is not physically able, from a pulmonary standpoint, to do his usual coal mine employment or comparable and gainful work. Patient is not able, from a pulmonary standpoint, to do comparable work in a dust-free environment. Patient is not able, from a pulmonary standpoint, to do comparable work in a dust-free environment. Instead, patient is able to do sedentary work.</p>			
DX 12 DX 28	9/2/98	Dr. Westerfield	10/8/99
<p>Dr. Westerfield's medical report based on his complete evaluation of Mr. Perry, as well as a review of certain medical records and Claimant's medical, social and occupational histories. <b>Comments:</b> Mr. Perry reported some respiratory symptoms for several years. He has mostly been short of breath with exertion. This has not inhibited his work activities but he did notice it at work. No prior history of pneumonia or tuberculosis and no history of asthma. Dr. Westerfield noted Claimant's work accident resulting in deep vein thrombosis of his legs which led to pulmonary embolism and apparent pulmonary infarction on his right lung. Dr. Westerfield reported that Claimant no longer smokes cigarettes – he quit in 1981, but started smoking as a teenager and smoked heavy before he quit. He has an estimated smoking history of twenty pack years. Following his evaluation, Dr. Westerfield diagnosed Claimant as having coal workers' pneumoconiosis with progressive massive fibrosis based on the large opacity present in his right upper lung field. Dr. Westerfield noted that this area of the lung that was biopsied in Mr. Perry with the concern that the large mass could represent lung cancer. According to Dr. Westerfield, Dr. Ferguson's microscopic interpretation is descriptive of progressive massive fibrosis. Dr. Westerfield further noted that the microscopic structures of progressive massive fibrosis is identical to that of coal nodules, but consists of a large quantity of the fibrotic nodules. In Mr. Perry's case, there were enough coal nodules coalescing together to have the radiographic appearance of progressive massive fibrosis. The concern for lung cancer, according to Dr. Westerfield, was valid because progressive massive fibrosis nodules can resemble lung cancer. <b>Impression:</b> (1) history of exposure to coal dust and underground coal mining; (2) episode of pulmonary embolism; (3) shortness of breath; and (4) chronic back pain secondary to injury. <b>Conclusion:</b> It is Dr. Westerfield's opinion that specimens of Mr. Perry's lung confirms his diagnosis of progressive massive fibrosis, complicated coal workers' pneumoconiosis.</p>			
DX 11 DX 13	9/9/98	Dr. Hoffnung	9/10/98
<p>Dr. Hoffnung's medical report is based on Claimant's CT scan which was performed at Bristol Regional Medical Center. <b>Conclusion:</b> Right upper lobe lesion on recent CT scan demonstrates intense hypermetabolism consistent with a neoplastic process. No evidence of mediastinal spread or spread elsewhere in the thorax is identified.</p>			

<i>Exhibit</i>	<i>Exam Date</i>	<i>Physician</i>	<i>Report Date</i>
DX 11	9/24/98 – 9/27/98	Dr. Roberts	10/2/97
<p>Dr. Roberts' medical report is in the form of a history and physical examination summary and a discharge summary as a result of Claimant's September 1998 hospitalization at Bristol Regional Medical Center. <b>History of Present Illness:</b> As a result of Claimant's mining accident, he suffered a lumbar spine fracture. During his hospitalization to repair this, Claimant developed DVT in the lower extremity. Following this, patient developed pulmonary embolus and a right hemithorax. He then underwent thoracoscopy with decortication for the entrapped lung. Recently, patient had a PET lung imaging scan that showed the right upper lobe lesion as seen on a recent CT scan demonstrating intense hypermetabolism consistent with a neoplastic process. After evaluation by Dr. Roberts, it was felt that patient would need a right thoracotomy with biopsy of this lesion and possible right upper lobectomy. <b>Past medical history:</b> (1) status post repair of lumbar spine fracture secondary to mining accident; (2) history of peptic ulcer disease; (3) history of tobacco use; (4) history of hemorrhoids; (5) status post amputation of right thumb; and (6) history of possible black lung. <b>Social History:</b> Patient worked as a miner and has been disabled since his mining accident. He is married and has one child in good health. He uses tobacco and occasionally uses ethanol. <b>Impression upon Admission:</b> (1) right lung mass; (2) status post right thoracoscopy with decortication of entrapped right lung secondary to hemothorax; (3) spinal fracture secondary to coal mining accident; (4) status post placement of Greefield filter; (5) pulmonary embolus, following placement of Greenfield filter; (6) history of tobacco abuse; (7) history of black lung; (8) depression; and (9) persistent pain from trauma. <b>Plan of Admission:</b> Patient is scheduled to undergo right thoracotomy with biopsy of the right upper lobe lung mass and possible right upper lobectomy. <b>Hospital Course:</b> A chest x-ray demonstrated a slight increase in patch infiltrates in the right mid lung zone and minimally in the left base. Lung fields were clear. A second chest x-ray demonstrated a worsening in the bilateral infiltrates and increase in the amount of pleural effusion on the right side. Lung sounds remained clear. A repeat chest x-ray later in the day suggested mild improvement of aeration in the right mid lung with no other significant interval changes. <b>Final Diagnosis:</b> Multiple fibrohistiocytic nodules associated with anthrasicotic material consistent with coal workers' pneumoconiosis.</p>			
DX 11 DX 13	9/24/98	Dr. Ferguson	9/25/98
<p>Dr. Ferguson's medical report is based on Claimant's biopsy performed to which three specimens were taken from his right lung. <b>Specimen One:</b> According to Dr. Ferguson, specimen 1 consists of a 5 x 2.5 x 2 cm wedge of lung tissue. A stapled suture line is present. The pleura is smooth to wrinkled, dark purple. Sectioning reveals a 1.5 cm well circumscribed charcoal gray parenchymal nodule. <b>Specimen Two:</b> Specimen 2 was taken from the upper lobe and consists of two slivers of black tissue which measures 0.5 x 0.2 cm together. <b>Specimen Three:</b> Specimen 3 was taken from the lower lobe and consists of 1 cm red-black soft to firm tissue fragment exhibiting a 0.5 cm dark gray indurated nodule. Several staples are present. <b>Microscopic Diagnostic:</b> Multiple fibrohistiocytic nodules associated with anthrasicotic material consistent with coal workers' pneumoconiosis, all specimens. Although simple macules are not prominent in the lung parenchymal adjacent to the nodules there is extensive deposition of anthrasicotic material including numerous silica crystals in the interstitium of the adjacent parenchyma. There is no evidence of neoplasm.</p>			

<i>Exhibit</i>	<i>Exam Date</i>	<i>Physician</i>	<i>Report Date</i>
DX 11	9/24/98	Dr. Roberts	9/24/98
<p>Dr. Roberts' medical report is in the form of an operative note arising out of the thoracotomy performed on Claimant during his September 1998 hospitalization at Bristol Regional Medical Center. <b>Preoperative Diagnosis:</b> (1) right upper and lower lobe nodules; (2) status post deep venous thrombosis; and (3) status post trauma with decortication, right. <b>Procedure Performed:</b> Thoracotomy with wedge resection of right lower lobe nodule and right upper lobe nodule as well as true cut needle biopsy of right upper lobe nodule. <b>History:</b> As a result of his mining accident, Claimant experienced deep venous thromboses and ended up with entrapped lung. He required thoracoscopy and underwent a decortication at that time. He has been doing well except for this continued mass on his right chest. At that time, it was consistent with pulmonary emboli. <b>Operative Report:</b> "We were able to get</p> <p>the mass in question where we could biopsy it. There were several good discrete nodules that were in the posterior aspect of the lower lobe and we were able to wedge these out. It was very hard, but we were also able to do a second biopsy of the upper lobe in a similar fashion and sent these for frozen section and then the larger confluence of masses in the upper lobe, we were able to do multiple true cut biopsies in this area. They all grossly appeared to be very hard anthracotic nodules. Frozen section diagnosis was consistent with benign fibrohistiocytosis and his lung certainly had an anthracotic appearance of coal miners disease." <b>Postoperative Diagnosis:</b> Benign fibrohistiocytosis.</p>			
DX 11 DX 13	9/24/98	Dr. Miller	9/24/98
<p>Dr. Miller's medical report is in the form of a radiology report arising out of a chest x-ray that took place during Claimant's September 1998 hospitalization at Bristol Regional Medical Center. <b>Comments:</b> Two right chest tubes are demonstrated with no significant pneumothorax. Asymmetrical pulmonary densities greatest in the right mid lung. This is accentuated by limited inspiration of vascular crowding. <b>Impression:</b> Post-thoracotomy changes with two right chest tubes and no significant pneumothorax. Asymmetrical ill-defined pulmonary densities greatest on the right.</p>			
DX 11 DX 13	9/25/98	Dr. Whisnant	9/25/98
<p>Dr. Whisnant's medical report is in the form of a radiology report arising out of a chest x-ray that took place during Claimant's September 1998 hospitalization at Bristol Regional Medical Center. <b>Comments:</b> As before, the right lung is expanded. There is some increased patchy infiltrate in the right mid lung zone and minimally left base. No other changes. <b>Impression:</b> Increase in infiltrates right lung.</p>			
DX 11 DX 13	9/26/98	Dr. Foster	9/26/98
<p>Dr. Foster's medical report is in the form of a radiology report arising out of a chest x-ray that took place during Claimant's September 1998 hospitalization at Bristol Regional Medical Center. <b>Comments:</b> When compared to the 9/25/98 study, Dr. Miller noted that there is no obvious recurrent or residual pneumothorax seen. There has been increasing pleural effusion which is along the lateral chest wall and extending now to the apex. Considerable infiltrate in the right mid and lower lung zone is seen. <b>Impression:</b> Worsening bilateral infiltrates. Increase in the amount of pleural effusion on the right. Chest tubes remain in place without obvious recurrent or residual pneumothorax.</p>			

<i>Exhibit</i>	<i>Exam Date</i>	<i>Physician</i>	<i>Report Date</i>
DX 11 DX 13	9/27/98	Dr. Miller	9/27/98
Dr. Miller's medical report is in the form of a radiology report arising out of a chest x-ray that took place during Claimant's September 1998 hospitalization at Bristol Regional Medical Center. <b>Comments:</b> When compared to the 9/26/98 x-ray, Dr. Miller noted that there is some mild improvement of the associated moderate atelectasis/infiltrate in the right mid lung with adjacent pleural thickening/effusion although some of this may be due to differences in technique. Moderate atelectasis in the left base is again noted and unchanged. <b>Impression:</b> Suggestion of mild improvement of aeration in the right mid lung with no other significant interval change.			
DX 11	10/1/98	Dr. Baron	10/2/98
Dr. Baron's medical report is in the form of a chart note and is based on his follow-up to Claimant's 9/24/98 thoracotomy. <b>Comments:</b> The PET scan had been positive and the biopsies failed to reveal any cancer, but instead pneumoconiosis. Now coughing up a grayish/black sputum at times. Claimant is still having a lot of pain in his right lung and has been nauseated with the Hydrocodone, but has not been helped by the Tylenol #3. Physical exam is unchanged except for the new scar that he has. Lungs are clear, no rales or rubs heard. <b>Impression:</b> (1) restrictive lung disease; (2) coal workers' pneumoconiosis – no cancer, right upper lobe; (3) uncontrolled pain; and (4) elevated cholesterol and markedly elevated triglyceride.			
DX 11	10/15/98	Dr. Roberts	10/15/98
Dr. Robert's medical report is in the form of a letter to Dr. Baron and is based on his evaluation of Mr. Perry. <b>Comments:</b> Claimant's wounds are healing well. He is making good and steady progress. His only complaint is of depression that he experienced after his first accident and surgery.			
DX 11	11/5/98	Dr. Baron	11/5/98
Dr. Baron's medical report is in the form of a chart note and is based on his evaluation of Claimant. <b>Comments:</b> Claimant is still having pain in his operative site. There is a burning, which is slightly better, but he has a scratchy sensation and is jarring with walking. The Demerol is making him irritable and he is hateful. Claimant is very depressed over his current state of disability and he is frustrated as he tries to learn to read and write. He has had thoughts of suicide, but is not keeping any guns at home. Claimant mentioned that he has a small mass in his right chest, posteriorly above the surgical scar and around the area of the scapula. Physical exam revealed slightly decreased breath sounds in the right chest. Claimant questioned of a possible fatty tumor that is about the size of a grape in the right posterior chest over the medial edge of the right scapula which is moveable, non-tender, and superior to his thoracotomy scar which seems to be healing well. He complained of a knot in his left buttock, but Dr. Baron reported that he could not feel it, even when he put his finger over the area Claimant complained. <b>Impression:</b> (1) coal workers' pneumoconiosis with no evidence of cancer, status post thoracotomy; (2) nodule, question fatty tumor in the right posterior chest; and (3) suicidal ideation.			

<i>Exhibit</i>	<i>Exam Date</i>	<i>Physician</i>	<i>Report Date</i>
DX 11 DX 12	12/18/98	Dr. Baron	12/18/98
<p>Dr. Baron's medical report is in the form of a chart note and is based on his evaluation of Claimant. <b>Comments:</b> Claimant is a little short of breath and has had slight improvement in the discomfort in the right axilla. It is unclear whether this is secondary to the Fentanyl that I gave him, or just tincture of time. Currently, Claimant can walk about 50 yards. Physical exam is unchanged. He has recently had a black lung evaluation in Kentucky and doesn't know the results of this. Also, he has symptoms of carpal tunnel, in which I was able to reproduce with having him flex his hands together, and I have given him bilateral wrist splints. Included in Dr. Baron's examination was a chest PA and lateral. Dr. Baron noted that the Chest PA film revealed that there was pleural thickening on the right side of the chest and an infiltrate aminating from the right hilum and the right upper lobe. Claimant's lateral chest x-ray showed a slight enlargement in the hilum, and there is an infiltrate posteriorly and superiorly, which could be either the posterior subsegment in the upper, or the superior segment in the lower lobe. <b>Interpretation:</b> (1) infiltrate right upper lobe; and (2) pleural thickening, right.</p>			
DX 11 DX 12	1/20/99	Dr. Baron	1/20/99
<p>Dr. Baron's medical report is in the form of a chart note and is based on his evaluation of Claimant. <b>Comments:</b> Claimant is having increasing shortness of breath in general with pain in his upper quadrant, which is sharp at times for the last month. He had some smothering last month. There has been no change in his physical examination. <b>Impression:</b> (1) coal workers' pneumoconiosis, status post surgery to rule out cancer; (2) chest wall pain; and (3) elevated triglycerides.</p>			
DX 11 DX 12 DX 27	1/29/99	Dr. Powell	1/29/99
<p>Dr. Powell's medical report is based on his evaluation of Claimant as well as his review of Claimant's occupational, medical and social histories, and his medical testing. <b>Comments:</b> Claimant stated that he worked 26 years in underground mines, with approximately the last nine with Del Rio Coal Company. He stopped working on September 4, 1996 when he sustained a back injury in a rock fall. Claimant stated that he has been short of breath for approximately two years and that he sees Dr. Barron once a month for his breathing. Claimant indicated that he has to stop because of shortness of breath after walking approximately 1/4 a mile on level ground. Claimant coughs, wheezes and awakens every night smothering. He even wheezes during the day at rest. Claimant has a cough most days particularly with exertion. Claimant has had chest pain in the right lateral chest since his hospitalization for back injury – he sustained a pulmonary embolism during that hospitalization in Sept. 1996. Claimant was also hospitalized in Aug. 1998 for a lung biopsy to which several spots in the right lung were removed and were found to be coal dust. Claimant began smoking cigarettes at age 16 and smoked 3 packs per day until he quit at the age of 30. His lungs revealed normal breath sounds with no rubs or crackles. His chest x-ray showed: infiltrate in the right middle and upper lung zone; rounded and irregular nodularity in both lungs when compared with the standard x-rays; and categorized the x-ray P/Q and T-A consistent with coal workers' pneumoconiosis. <b>Impression:</b> (1) Abnormal chest x-ray consistent with category I/I Q and P and T-A coal workers' pneumoconiosis; (2) Status post right thoracotomy for pulmonary biopsy; and (3) Invalid pulmonary function studies.</p>			

<i>Exhibit</i>	<i>Exam Date</i>	<i>Physician</i>	<i>Report Date</i>
DX 11 DX 12	3/12/99	Dr. Baron	3/12/99
<p>Dr. Baron's medical report is in the form of a chart note and is based on his evaluation of Claimant. <b>Comments:</b> Claimant says the pain in his chest is no better and is 9 out of 10. The pain in his back is no better and is 10 out of 10. Plus, he has numbness of his legs bilaterally. He is to see Dr. Burt next month for re-evaluation. Claimant's request for a pain consultation has been denied by his workers' comp company. There is no change in physical exam. <b>Impression:</b> (1) pain in thoracotomy site; (2) hypertriglyceridemia; (3) pain in back with numbness in the legs; and (4) coal workers' pneumoconiosis with conglomerate lesion, right upper lobe.</p>			
DX 12	5/10/99	Dr. Kennedy	5/10/99
<p>Dr. Kennedy's medical report is based on an independent medical examination of Claimant. Additionally, Dr. Kennedy reviewed Mr. Perry's medical, social and occupational histories, as well as the diagnostic testing that was performed in connection with this matter. <b>Comments:</b> Claimant still has constant pain in the lumbosacral region and coccygeal region. The coccygeal pain is not increased during a bowel movement. All of his pain is particularly aggravated by activities requiring bending. The pain has caused him to give up activities requiring stooping, squatting, kneeling, reaching, bending, twisting or pulling and to reduce to positions and activities requiring leaning. The pain interferes with his ability to have sex. The pain prevents standing or walking longer than about 15 minutes and it prevents sitting longer than about 30 to 90 minutes depending on his posture while sitting. After prolonged standing, he has positional numbness in the anterior aspect of the left thigh and groin. He also has stabbing, fleeting pain in the anterior aspect of the left knee associated with the numbness. In addition, he has intermittent generalized stabbing, stinging pain in the right foot associated with walking and standing. The right foot symptoms have improved over time. Shortly after the injury and for about one year, the right foot was so sensitive that he could hardly bear wearing a shoe or having anything touch the right foot. The right foot still gets cold easily. Physical examination revealed that Claimant stood with slight flexion in the hips and walked smoothly using a quad cane in the left hand to protect the left foot. He was able to stand without any hip flexion when asked to do so. He did not limp when he did not use the cane, but his gait appeared less sure</p> <p>without the cane. He had well healed scars in the lumbar region consistent with the record of surgery. Under direct observation, he demonstrated about 25% normal range of motion. He moved through the maneuvers of the examination with good coordination and without hesitation. Straight leg raising was negative bilaterally with the patient sitting and supine. The lower extremity deep tendon reflexes were bilaterally equal and normal. There was no suggestion of any neurovascular deficits in the lower extremities. The Babinski's were bilaterally plantarward and there was no clonus. <b>Impression:</b> Traumatic spondylolisthesis L5 with bilateral facet fractures. Compression fractures of L1, L2, L3 and L4. Transverse process fractures of L1-L5 (5 levels) on the right and of L4-L5 (2 levels) on the left. <b>Conclusions:</b> There was very good correlation between the objective findings and the symptoms described above. Assuming the foregoing history to be reasonably accurate and thorough, I can state the following with reasonable medical certainty. The mining accident of 9/4/96 caused the multiple injuries to the lumbosacral spine as listed and caused the residual symptoms and abnormal findings described. I did not evaluate his lung condition because that is beyond the scope of my specialty of orthopedics.</p>			

<i>Exhibit</i>	<i>Exam Date</i>	<i>Physician</i>	<i>Report Date</i>
DX 11 DX 12	5/25/99	Dr. Baron	5/25/99
Dr. Baron's medical report is in the form of a chart note and is based on his evaluation of Claimant. <b>Comments:</b> Claimant feels that he gets very hot when he lays face down. He still has smothering at night. He is not taking his temperature, so it is hard to tell when he is having fever. He complained of pain in his tailbone, and has recently seen Dr. Burt. His chest pain is better at 8/10, because it had been 9/10. His lumbar area also continued to hurt. Claimant recently drove on the wrong side of the road and doesn't know whether it is secondary to medications or not. Physical exam is unchanged. <b>Impression:</b> (1) chest pain; (2) back pain; (3) hyperlipidemia; and (4) depression.			
DX 11 DX 12	7/9/99	Dr. Baron	7/12/99
Dr. Baron's medical report is in the form of a chart note and is based on his evaluation of Claimant. <b>Comments:</b> Claimant is not sleeping well even with the two Oxycontin at night. That is controlling his back pain, however he is complaining of smothering at night, as well as tossing and turning and sweats. His wife and he also say that he has a lot of jerking of his legs and kicking of his arms and legs. Back pain is unchanged. He is requiring Oxycontin at night and is hardly driving at all – his wife took the keys away because he did have some possible blackouts while driving. Physical exam revealed a middle aged white male in no acute distress. <b>Impression:</b> (1) back pain, secondary to an accident; (2) chest wall pain with secondary shortness of breath; (3) nocturnal myoclonus; (4) hypertriglyceridemia; and (5) hypercholesterolemia.			
DX 12	8/9/99	Dr. Patel	8/12/99
Dr. Patel's medical report is based on his psychiatric evaluation of Mr. Perry. <b>Comments:</b> Claimant's chief complaint was depression and pain. Claimant has been suffering from low back pain status/post mining accident. He has a history of Black Lung Disease. Since his injury, patient has become severely depressed. He has been having decreased sleep/appetite, feelings of hopelessness/helplessness. He has not been eating well. He has been losing weight and has been having suicidal ideations. Patient had verbalized thoughts, but no plans at this time. Patients has been having these symptoms in spite of receiving anti-depressants from his personal physician. <b>Diagnosis:</b> Axis I: Major depressive disorder-depressed type moderate to severe. Axis II: Borderline intellectual functioning person. Axis II: Transverse process fracture of L1-L4 on the right, L4-L5 on the left, L1 vertebral fracture incomplete fracture of L2 lamina, fracture to L5-S1 facets. Status/post posterior interbody fusion Arthrodesis of L5-S1, placement of Greenfield filter. Axis IV: Psychosocial stressors – severe physical injury, burning of house. Axis V: Current GAF – 50. <b>Conclusions:</b> After a review of Claimant's history of present illness, medication history, medical history, personal history, educational history, legal history, marital history and a mental/status examination, Dr. Patel concluded that, at this time, patient is severely depressed. Patient's work injury has left him crippled with chronic pain. Patient is having decreased sleep, appetite, crying spells, difficulty with concentration, feelings of hopelessness/helplessness and suicidal ideations. Patient's condition is not due to arousal of a preexisting dormant nondisabling condition or congenital abnormality. Patient did not have an active psychological impairment prior to this injury. Patient has not related the physical and mental requirements of his usual and customary work activities. Patient is totally disabled and does not retain the physical capacity to return to the type of work performed at the time of his injury.			

<i>Exhibit</i>	<i>Exam Date</i>	<i>Physician</i>	<i>Report Date</i>
DX 11 DX 12	8/19/99	Dr. Baron	8/19/99
<p>Dr. Baron's medical report is in the form of a chart note and is based on his examination of Mr. Perry.</p> <p><b>Comments:</b> Claimant complained of a large change in his eyesight, with being unable to see past 10 feet. He is still complaining of smothering, which is worse at night and is especially bad in hot and humid weather. There is a pain under his right breast and to his axilla. The pain is an 8 or 9 out of 10 and lasts for about 5 minutes. It is worse when he walks and he has to breathe deeply or lays down. He cannot walk more than about 50 yards because dyspnea on exertion developing into pain. He said he had pressure in his right chest before surgery, but has pain and pleurisy post surgery. He said the pain is a 9 out of 10 when it hits him. Subjectively, he feels that he can lift less than 10 pounds. This can be done occasionally with pain as mentioned. He can squat with great difficulty, is dizzy, and cannot get up without his cane. He has pain in his back all the time and cannot sit for very long periods of time, probably no more than 15 minutes or more, when he gets stiff and pain in his back. He probably can stand, he feels, for 1 to 1.5 hours in an 8-hour day with pain. He can walk only 3-4 steps before it hurts him. He and his wife say they do not dance any more and there has been a marked decrease in their sex life. Previously, he could work 8-16 hour shifts and come home and look for more work. This was before the accident. There has been no change in the physical exam except for the fact that he has actually stuck to the diet since 6 weeks ago, and has lost 22 pounds. <b>Impression:</b> (1) back pain; (2) pleurisy; and (3) decreased vision, rule out secondary to Lopid.</p>			
DX 28		Dr. Westerfield	10/8/99
<p>Dr. Westerfield's medical report is in the form of a letter and is based on his Sept. 2, 1998 evaluation of Claimant and his review of Claimant's medical records regarding coal workers' pneumoconiosis and a surgical pathology report dated Sept. 24, 1998. <b>Comments:</b> At time Dr. Westerfield performed his evaluation, he diagnosed Claimant as having coal workers' pneumoconiosis with progressive massive fibrosis. His diagnosis was based on the large opacity present in his right upper lung field. Dr. Westerfield reported that it was this area of the lung that was biopsied with the concern that the large mass could represent lung cancer. Dr. Westerfield reported that Dr. Ferguson's microscopic interpretation is descriptive of progressive massive fibrosis and that the microscopic structures of progressive massive fibrosis is identical to that of coal nodules, but consists of a large quantity of the fibrotic nodules. In Mr. Perry's case, there were enough coal nodules coalescing together to have the radiographic appearance of progressive massive fibrosis. The concern for lung cancer was valid because progressive massive fibrosis nodules can resemble lung cancer. <b>Conclusion:</b> In summary, it is Dr. Westerfield's opinion that the specimens of Mr. Perry's lung confirms his diagnosis of progressive massive fibrosis, complicated coal workers' pneumoconiosis.</p>			
DX 14	11/12/99	Dr. Hudson	11/12/99
<p>Dr. Hudson's medical report is based on his physical examination of Claimant, as well as his review of Claimant's medical records/history and his occupational and social histories. <b>Comments:</b> Claimant worked in coal mines for 26 years as a miner operator – all underground work. Last worked on September 4, 1996 due to mining accident.</p> <p>Mr. Perry has a history of pleurisy since 1996. He was hospitalized for 8 weeks in September 1996 as a result of his mining accident. Claimant stopped smoking in 1981 after having smoked since he was 15 years of age. During that</p>			

<i>Exhibit</i>	<i>Exam Date</i>	<i>Physician</i>	<i>Report Date</i>
<p>time, Claimant smoked a maximum of 2 packs per day. On the day of the examination, Claimant presented complaints of: sputum, for 4 years and occurs most days – grey in color; wheezing, frequently at night since 1996; dyspnea for 25 years; cough, brief most days to clear sputum in the a.m.; chest pain, constant on right since 1996; orthopnea, 2 pillows; ankle edema, controlled and diuretic since 1996; and paroxysmal nocturnal dyspnea, restlessness or sleep apnea. Claimant also complained of tingling in the hands and legs, and of poor balance – walks with a quad cane. Upon review of Claimant’s chest x-ray, Dr. Hudson concluded that it revealed complicated coal workers’ pneumoconiosis. <b>Diagnosis:</b> (1) complicated coal workers’ pneumoconiosis based on Claimant’s long history of coal dust exposure, his chest x-ray and open lung biopsy which are indicative of coal workers’ pneumoconiosis. Dr. Hudson noted no impairment which prevents Claimant from performing his last coal mining job.</p>			
DX 25	12/3/99	Dr. Broudy	12/3/99
<p>Dr. Broudy’s medical report is based on evaluation of Claimant for an occupational pulmonary disease, as well as his review of the additional medical evidence connected to this matter and Claimant’s medical, social and occupational histories. <b>Comments:</b> Mr. Perry quit smoking in 1981 after consuming 1 to 1 ½ packs per day for about 12 – 14 years. He worked 25 or 26 years in underground coal mining and worked steadily until he was injured in a rock fall accident. Claimant now walks with the help of a 4-pronged cane. He is unable to read or write. He has trouble sleeping because of low back pain and smothering when lying down. On the job, prior to the injury, he had no trouble with his breathing. He says he is now limited with regards to exertion because of his back and breathing problems. He has cough and black or gray colored sputum since before he quit work in the mines. He has intentionally lost some weight. There is no history of hemoptysis or fever. He has had swelling in his feet and his legs and his wife notes that he has sweating at night. He complains of right lateral chest wall pain due to the incision over the right chest. He says that he experienced pain during pulmonary function testing and also became dizzy during the PFT. Physical examination revealed that the lungs are clear to auscultation and percussion. Spirometry revealed a borderline restrictive defect. There is slight improvement after bronchodilation to the point where the vital capacity and FEV1 are both normal. The patient’s effort was satisfactory except for the MVV component where it was suboptimal. The arterial blood gas study is normal on room air at rest except for elevation of the carboxyhemoglobin indicating continued exposure to smoke. Chest x-rays are of good quality. There is some volume loss in the right lung. There is a background of interstitial nodularity, particularly in the mid and upper zones. In addition, there is at least one large opacity in the right upper zone measuring approximately 4 x 3 cm. There is also haziness along the right lateral chest wall which is undoubtedly due to the previous hemothorax and pleural reaction. Findings are consistent with complicated coal workers’ pneumoconiosis with a background of early simple pneumoconiosis. I would categorize the films as category 1/1, q/t in the mid zones and right upper zone. The lesion in the large opacity would be considered stage A. Mr. Perry certainly has a history of sufficient exposure to cause pneumoconiosis in a susceptible host. The radiographic and pathological findings are supportive of a diagnosis. The injury or the chest complicates interpretation of the chest film and perhaps may also complicate interpretation of the pathological material obtained at biopsy. Certainly another opinion regarding the lung biopsy may be helpful. Also, it would be extremely helpful to have chest x-rays taken prior to the injury. I would expect this large opacity would have been present even prior to the injury. If the large opacity was not present at that time, then it would imply that the opacity resulted from the injury itself rather than coal workers’ pneumoconiosis. From a strictly respiratory standpoint, Mr. Perry would retain the respiratory capacity to perform the work of an underground coal miner or to so similarly arduous manual labor. <b>Diagnoses:</b> (1) radiographic and pathological findings suggestive of complicated coal workers’ pneumoconiosis; and (2) traumatic injury to the lumbar spine and chest.</p>			
DX 27		Dr. Naeye	1/22/00
<p>Dr. Naeye’s medical report is based on consultation findings and a review of Claimant’s medical records and</p>			

<i>Exhibit</i>	<i>Exam Date</i>	<i>Physician</i>	<i>Report Date</i>
<p>diagnostic testing. <b>Comments:</b> The major pulmonary problems now experienced by Claimant are the consequence of accidental trauma that he sustained mining coal rather than to exposure to coal mine dust. Dr. Naeye reported that a 1997 CT scan revealed a lesion in the lower part of Claimant's right upper lung lobe and in the adjacent area of his right lower lung lobe. The lesion, according to Dr. Naeye, was 5 x 2.5 x 2 cm in its dimensions and charcoal-gray (not deep black) in color when it was excised on 9/24/98. On microscopic examination of the slides with this lesion, Dr. Naeye made the following findings: It is a typical silicotic nodule that has grown over a number of years to the size it reached in 1998. Its center is comprised of old, hyalinized collagen with only a few birefringent crystals at those points where small amounts of black pigment have been trapped in the collagen. As one leaves this central area, old granulation of tissue appears with a small to moderate amount of admixed black pigment and many birefringent crystals of all sizes. At its periphery, the granulation tissue is more recent in origin and the same mixture of small amounts of black pigment and birefringent crystals are present. Except at its hyalinized center, there are many undamaged blood vessels within the lesion. In this latter characteristic, it in no way resembles the lesion of complicated coal workers' pneumoconiosis in which obliteration of blood vessels is a characteristic feature with resulting necrosis in the center of the lesion that resembles black ink. The lesion also does not fit the description of CCWP in another important respect – it has not arisen against the background of many obvious anthracotic macules and micronodules which indicate simple CWP long antedated its appearance. <b>Interpretation:</b> This man may still have impairments in lung function secondary to the trauma he sustained in 1996. If he is still very obese he is likely disabled, by a combination of direct damage caused by the 1996 trauma, multiple pulmonary arterial emboli, and the sleep apnea syndrome. The lesion resected from his right lung in 1998 is a silicotic nodule. It does not have any of the characteristic microscopic features of complicated coal workers' pneumoconiosis. If because of its size (5 x 2.5 x 2 cm) others may wish to classify it as complicated coal workers' pneumoconiosis that would be a legal rather than a scientific or medical judgment. I cannot see how this silicotic nodule, resected or not, could have a measurable effect on lung function and thus be preventing this man from returning to work mining coal.</p>			
DX 27		Dr. Powell	2/2/00

<i>Exhibit</i>	<i>Exam Date</i>	<i>Physician</i>	<i>Report Date</i>
<p>Dr. Powell's medical opinion is in the form of his deposition testimony. Dr. Powell testified that he evaluated Mr. Perry on January 29, 1999 in order to determine whether he had changes consistent with coal workers' pneumoconiosis or respiratory impairment. According to Dr. Powell, his evaluation consisted of reviewing Claimant's work history, a physical examination, diagnostic testing and a lateral chest x-ray. With regards to the chest x-ray taken on the day of the evaluation, Dr. Powell testified that he interpreted as positive for coal workers' pneumoconiosis, classifying it as 1/1, Q and P and T-A. In laymen terms, Dr. Powell described the x-ray findings as having both rounded and irregular markings or nodules, both small and medium size rounded ones and medium size irregular ones; and he had nodules larger than a mm, but not in aggregate sufficient volume to more than fill the left upper lung zone. In regards to the pathology report arising out of Claimant's lung biopsy, Dr. Powell testified that a finding from the pathologist is more near the reality because (he/she) is looking directly at the tissue, whereas a finding on a chest x-ray is a shadow. Upon reviewing Dr. Naeye's pathology findings along with his own evaluation of Mr. Perry, Dr. Powell testified that Claimant does not have the usual massive progressive fibrosis associated with coal workers' pneumoconiosis. On cross-examination, Dr. Powell testified to have not having a chance to review the pathology readings of the pathologist who originally read them. Dr. Powell testified that his categorization of Claimant's chest x-ray as showing an "A" lesion means that it is greater than a cm, but less than 5 cm. As far as his x-ray diagnosis, Dr. Powell categorized it (x-ray) as complicated coal workers' pneumoconiosis. Furthermore, Dr. Powell testified that complicated pneumoconiosis is synonymous with progressive massive fibrosis. As far as Claimant's diagnostic testing, Dr. Powell testified that Claimant's breathing studies and arterial blood gas studies as abnormal (with the AGB's showing a mild arterial hypoxemia). On re-direct examination, Dr. Powell stated that the lesion/nodule that he interpreted as complicated coal workers' pneumoconiosis on the x-ray was different from the one that was taken from the biopsy – the one that was taken from the biopsy is not the only one that was present in the lung – essentially there were more than one present.</p>			
DX 28		Dr. Westerfield	2/21/00
<p>Dr. Westerfield's medical report is in the form of a letter and is based on his review of the pathological reports of Drs. Ferguson and Naeye. <b>Comments:</b> The reports arise out of a lung biopsy which was performed on September 24, 1998. In a previous letter dated October 8, 1999, Dr. Westerfield stated that he agreed with Dr. Ferguson's interpretation of the lung tissue as showing coal workers' pneumoconiosis which represented progressive massive fibrosis. Dr. Westerfield noted that Dr. Naeye, on the other hand, diagnosed silicosis on this same tissue specimen, but opined that complicated coal workers' pneumoconiosis is not present. Dr. Westerfield further noted that Dr. Naeye made several findings on Mr. Perry's pathological specimen that are relevant to the diagnosis of progressive massive fibrosis: (1) On microscopic examination, it is typical silicotic nodule that has grown over a number of years to the size it reached in 1998. (2) The nodule specimen is 0.5 x 2.5 x 2.0 cm which by definition is progressive massive fibrosis. (3) Dr. Naeye gives a good description of fibrosis, birefringent crystals, black pigment and granulation tissue in various degrees of organization. (4) Dr. Naeye's concern of undamaged blood vessels within the lesion reflects the age of the process, not the lack of appropriate pathology. The tissue is from a 47 year old man. In a few more years, this mass would be larger and show more of the classical features of progressive massive fibrosis. (5) Regarding Dr. Naeye's suggestion that Mr. Perry's biopsy specimen has not arisen against a background of simple coal workers' pneumoconiosis one must remember that this pathological specimen is only a biopsy of the mass lesion, not the entire lung (or even a lobe). Also, Mr. Perry's chest radiographs show the appropriate background of coal macules with a profusion level of ½. <b>Conclusion:</b> It remains my opinion that Mr. Perry has complicated coal workers' pneumoconiosis and this pathological tissue supports that diagnosis.</p>			
DX 28	3/23/00	Dr. Westerfield	3/23/00

<i>Exhibit</i>	<i>Exam Date</i>	<i>Physician</i>	<i>Report Date</i>
<p>Dr. Westerfield's medical opinion is in the form of deposition testimony. Dr. Westerfield testified that he is a specialist in pulmonary medicine. Dr. Westerfield further testified to seeing Mr. Perry on September 2, 1998 for an occupational respiratory evaluation, which consisted of a complete history with emphasis on occupational history and chest history and previous respiratory history, physical examination with emphasis on chest findings, PA chest x-ray, spirometry and a diffusing capacity. With respect to the physical examination, Dr. Westerfield testified that there were no significant findings. With respect to the chest x-ray conducted on the date of the evaluation, Dr. Westerfield opined that: it shows coal workers' pneumoconiosis. It actually shows progressive massive fibrosis. It has both small opacities in a q/p size and shape in all 6 zones, profusion level of ½ and a large opacity of an "A" category which puts it into a progressive massive fibrosis. Dr. Westerfield next testified that the term progressive massive fibrosis is the same as complicated coal workers' pneumoconiosis. When he first reviewed the film, Dr. Westerfield was concerned that Claimant had some type of cancer, lung cancer – specifically, the abnormality in the right upper lung field was quite suspicious for neoplasm and that is characteristic of progressive massive fibrosis in early stages. However, there was no change in an x-ray that was taken later in the year, which led Dr. Westerfield to believe that it was likely not cancer. When questioned about the pathologist's reports concerning the biopsy slides, Dr. Westerfield testified that Mr. Perry is classic for complicated coal workers' pneumoconiosis. He has the appropriate history; he has the x-ray findings; he even has pulmonary function studies that support that and he has an actual tissue biopsy that shows the presence of coal workers' pneumoconiosis. Dr. Westerfield was next questioned about how a person can have progressive massive fibrosis with a normal, or slightly below normal, lung function, to which he replied that Claimant is early – simple coal workers' pneumoconiosis, if you remove the individual from the offending coal dust, the disease process stops; it doesn't progress. On the contrary, the progressive massive fibrosis, as the name would indicate, is a progressive disease. It is probably because there is more silica involved than pure coal dust – silica is a lot more fibrogenic which is going to cause continued tissue reaction over time. Mr. Perry is early in this – he is a young man, only 47 years old. His lung function will be much worse than this in ten years. A classification of "A" is anywhere from 10 mm to 50 mm. "B" opacities are bigger than 50 mm, but smaller than the size of the right upper lobe, while a "C"</p>			
<p>classification is bigger than the right upper lobe size. The Claimant's lesion is about 3 cm. Dr. Westerfield lastly testified on direct that Claimant's impairment, which he found as a result of testing, is caused from coal workers' pneumoconiosis. On cross-examination, Dr. Westerfield testified that there was no change in the pulmonary function studies, dated December 12, 1996 and December 3, 1997. Furthermore, Dr. Westerfield testified that the results of the 1998 pulmonary function studies were probably a little better; however, Dr. Westerfield stated that we should look at absolute numbers rather than present predicted no's particularly since Mr. Perry is measured at 2 inches taller and 30 pounds heavier since 1996. When comparing these results to Claimant's 1999 studies, Dr. Westerfield acknowledged that the raw numbers were higher than the 1996 and 1998 studies; however, Dr. Westerfield stated that a more sensitive study would be diffusing capacity for exercise study because spirometry shows improvement. On re-direct examination, Dr. Westerfield testified that, regardless of the pulmonary function studies over this period time, it is still his opinion that Claimant has progressive massive fibrosis. On re-cross examination, Dr. Westerfield testified that, based on the pulmonary function studies of December 3, 1999, Mr. Perry retained a respiratory pulmonary capacity to perform his usual coal mine work. Dr. Westerfield further testified that he noted two large opacities on the chest x-ray, with the largest located in the right upper lung field (3 cm) and the smaller in the right mid lung zone (1.5 cm). Dr. Westerfield testified that these figures fit the definition of progressive massive fibrosis under the Federal Standard. Furthermore, Dr. Westerfield testified that the definition of progressive massive fibrosis under the ILO classification is the presence of a large opacity of 10 mm on chest x-rays in someone with coal workers' pneumoconiosis or silicosis</p>			
DX 31	3/23/00	Dr. Ferguson	3/23/00

<i>Exhibit</i>	<i>Exam Date</i>	<i>Physician</i>	<i>Report Date</i>
<p>Dr. Ferguson's medical report is in the form of a letter to Dr. Baron and is based on his review of Claimant's pathology studies in conjunction with his own report as well as Dr. Naeye's pathology report. <b>Comments:</b> Dr. Ferguson noted that Dr. Naeye described the lesion as if it was a single lesion measuring 5 x 2.5 x 2 cm in maximal dimension. However, Dr. Ferguson reported that they have received three different specimens, ranging in size from 0.5 to 1.5 cm. Dr. Ferguson further reported that at least two of these specimens are palpable nodules measuring 0.5 and 1.5 cm in maximal dimension that, according to the surgical requisition, are separate lower lobe lesions. Additionally, Dr. Ferguson reported that there is a similar lesion of uncertain size, but measuring at least 0.5 cm, judging from the gross description of specimen #2, present in the right upper lobe. In addition to these palpable nodules in slide D of specimen #1, which represents pulmonary tissue adjacent to the palpable mass, two small coal dust macules are present. <b>Summation:</b> It would appear that there are at least three palpable and/or radiographically evident nodules present ranging in size from 0.5 to 1.5 cm as well as coal dust macules in the small amount of adjacent lung tissue in specimen #1. Taking these findings in context with this patient's coal mining history, I very comfortable with my previous interpretation that these findings are consistent with coal workers' pneumoconiosis. I do not know the duration of the exposure history in this case and have not reviewed the x-ray findings.</p>			
DX 31	4/7/00	Dr. Baron	4/7/00
<p>Dr. Baron's medical report is in the form of a letter and is based on the pathology reports derived from Claimant's pathology slides. <b>Comments:</b> Dr. Baron noted that Dr. Ferguson, in his report, points out that the pathologist incorrectly noted that there was 5 x 2 ½ x 2 cm lesion that was resected, but in fact that was the size of the wedge of lung tissue. Dr. Baron further noted that his pathologist initially had seen that the tissue was black in one spot and another 1 cm lesion red-black and another was dark gray. Dr. Baron stated that he does not know how Dr. Naeye got the idea of the smaller nodules, but there was a large mass that he was reluctant to take out, but did true cut biopsies in the areas of the "large confluence of masses in the upper lobe." Dr. Baron further reiterated Dr. Roberts' report wherein it was stated that "they all grossly appear to be very hard anthracotic nodules" and that Claimant's "lungs certainly had an anthracotic appearance of coal miners' disease." When referring to Dr. Naeye's medical report, Dr. Baron provided that Dr. Naeye had no right to talk about Mr. Perry being very obese – he is 229</p>			
<p>pounds, and his weight when he last worked in the mines was around 190 pounds. Dr. Baron pointed out that Claimant does not have sleep apnea syndrome and Dr. Naeye's statement that he may have this is a clinical one which is unsupported. <b>Conclusions:</b> Dr. Baron is confident in making the diagnosis of complicated coal workers' pneumoconiosis with progressive mass of fibrosis. Lastly, Dr. Baron stands by his original letter, dated 11/12/99.</p>			
DX 38 DX 29	5/2/00	Dr. Wiot	5/2/00

<i>Exhibit</i>	<i>Exam Date</i>	<i>Physician</i>	<i>Report Date</i>
<p>Dr. Wiot's medical report is based on his review of a large series of Claimant's chest x-rays, three sets of his chest CT scans and his pathology reports. <b>Conclusions:</b> There is no evidence of coal workers' pneumoconiosis. Although most films are unreadable for evaluation of pneumoconiosis, the 9/30/96 study which is a portable study shows a massive right pleural effusion. Subsequent films show insertion of a thoracostomy tube, which was removed on 10/7/96. The series of films dated 10/16/96, 1/14/97 and 8/26/98 are important in the overall evaluation of the patient. The 10/16/96 study shows evidence of loculated effusions and infiltrate present within the posterior segment of the right upper lobe, with associated air bronchograms indicating that it is an air space problem. The 1/14/97 study shows resolution of the air space change, with thickening of the major fissure in its superior aspect and some pleural disease extending along the right lateral chest wall, but a definite improvement from 10/16/96. The 8/26/98 study shows residual thickening of the superior aspect of the right major fissure, with a new ill-defined density in the posterior segment of the right upper lobe, which was not present on 1/14/97 and definitely smaller than it was on 10/16/96. This sequence of events in itself indicates that it is not a large opacity as was reported pathologically. The timing is totally inappropriate. The CT scans show no small opacities to indicate the presence of coal workers' pneumoconiosis. The CT scan of 9/27/96 shows, in addition to pleural disease, pulmonary infiltrate involving the bases of the lungs as well as the upper lung fields with air bronchograms. This would indicate that this is an air space problem, not a large opacity. Of importance is the fact that between the 1996 studies and the 3-7-97 study, there has been a significant change in this process, and there is stranding extending to the right hilum and air bronchograms consistent with an inflammatory process. The 6/22/98 again shows significant change in this process. Although this process appears more solid in its character, the significant change which occurs between 1996, 1997 and 1998 would indicate that this is residual of a past inflammatory process and not the development of a large opacity. The process is too rapid for development of a large opacity and its character early on is totally against that. In summary, neither the CT scans nor the chest x-rays show any evidence of coal workers' pneumoconiosis. The changes within the right upper lobe are almost assuredly the residual of an inflammatory process which was present early in this patient's course, shown by the changes which occur over the interval.</p>			
DX 38	7/10/00	Dr. Wiot	7/10/00
<p>Dr. Wiot's medical opinion is in the form of deposition testimony. Dr. Wiot testified that he had the opportunity to review a large series of x-ray films and a set of CT scans. At the time he interpreted these x-ray films, Dr. Wiot assumed that Mr. Perry had had sufficient exposure to coal mine rock and sand dust in which to contract the disease of coal workers' pneumoconiosis if he were a susceptible individual. Talking about his interpretation of the x-ray films, Dr. Wiot stated that not all the films were of acceptable quality – vast majority of these films were portable films. Based on the films that were of sufficient quality and the CT scans, Dr. Wiot testified that he interpreted them to show no evidence of coal workers' pneumoconiosis. Dr. Wiot disagreed with the pathology reports which determined complicated pneumoconiosis and the radiographic interpretations which indicate a large opacities of complicated pneumoconiosis. In doing so, Dr. Wiot for one reasoned that Claimant has no simple coal workers' pneumoconiosis. The CT scans show no nodules consistent with simple coal workers' pneumoconiosis and I have never seen a patient who had a large opacity with no evidence of simple coal workers' pneumoconiosis. I recognize that you can have pathologically simple coal workers' pneumoconiosis at a minimal degree and we not see it radiographically, but the combination of 3 CT scans showing no evidence of simple coal workers'</p>			

<i>Exhibit</i>	<i>Exam Date</i>	<i>Physician</i>	<i>Report Date</i>
<p>pneumoconiosis would be strongly against this being a large opacity also. Secondly, Dr. Wiot stated that the mass which they are talking about in the right upper lung field, if you look at the sequence of events and the sequence of films, Claimant had changes which occurred in this right upper lung early on in 1996, and this had air bronchograms in it, which was obviously an inflammatory process. Claimant had a lot of inflammatory disease – he had pleural effusion. But this was the 9/27/96 CT scan that showed this infiltrate in the upper lung field with air bronchogram and this would say it was an airspace problem and not a large opacity. And then between the studies of 9/27/96 and 3/7/97, there was a significant change in this process with stranding extending to the right hilum and again an air bronchogram. Now you know, air bronchogram or large opacities don't change in this short period of time, that is, in a six-month period. And then the study of 6/22/98 again showed a change in the process. So that is the reason that I don't agree that this is a large opacity – this rapid change is not consistent with large opacities, which tend to be very stable over a long period of time. As for the cause of the abnormal findings on Claimant's x-ray which have been interpreted as complicated pneumoconiosis, Dr. Wiot opined that he has the residual of an inflammatory process up in his right upper lobe – I don't see the nodules which apparently are/were seen pathologically.</p>			
EX 2 <sup>4</sup>	2/25/01	Dr. Jarboe	2/25/01
<p>Dr. Jarboe's medical report is based on his review of the Claimant's medical records in connection with this matter. Also taken into account were Mr. Perry's occupational, medical and social histories. <b>Conclusion:</b> After reviewing the large volume of medical records, Dr. Jarboe concluded, within a reasonable degree of medical certainty, that Mr. Perry does not have complicated pneumoconiosis, with his reasoning being that the pathological material does not confirm a diagnosis of complicated pneumoconiosis. To make this diagnosis, there must be a nodule that is 2 cm or greater in diameter in the lung tissues. It does appear that Claimant has a 1.5 cm silicotic nodule, but this does not constitute a diagnosis of complicated coal workers' pneumoconiosis. The other nodule lesion present and described by Dr. Ferguson was 0.5 cm in diameter. One may argue that the needle biopsies of the hard right upper lobe nodular lesion constitute the diagnosis of complicated pneumoconiosis, but I do not believe this is the case based on the following: (1) Most importantly, I do not feel the hard nodular lesions palpated by the surgeon and visualized on x-ray by numerous readers represents the lesion of complicated pneumoconiosis. The radiographic and clinical information clearly indicates that this lesion was not present when Mr. Perry was injured on 9/4/96. Had Mr. Perry had a lesion of progressive massive fibrosis, it would surely have been mentioned since it could have the appearance of a contusion and the physicians were looking for this type of abnormality. (2) There is also radiographic evidence that Mr. Perry did not have any space occupying mass in the right upper lobe at the time of his injury. A CT scan of 9/27/96 showed a pulmonary embolus in the right main pulmonary artery and volume loss in the right lung base, but no mention of a mass or nodular lesion in the right apex of the lung. (3) A ventilation perfusion scan of 9/12/96 was completely normal showing good ventilation and perfusion of the upper lung zones. However, when a lung scan was repeated on 1/14/97, there was a ventilation and perfusion defect in the right mid and upper lung zone. The lesion of progressive massive fibrosis could not have developed that rapidly. On the other hand, the medical evidence clearly indicates that Mr. Perry sustained a pulmonary embolus and infarction with hemorrhage into the lung which I feel caused the residual mass in the right upper lung zone. The final bid of radiographic evidence which tends to prove causation of the upper lobe nodular lesions is the description of the sequential CT scans by Dr. Wiot and also the sequential readings of the chest x-rays. These studies clearly showed that there was progressive improvement (although never total clearing) of the lesions in the chest. Progressive massive fibrosis would not improve once it appeared. (4) It is also quite clear that the Claimant's</p>			

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<sup>4</sup> It should be noted that this document was attached to the transcript of Dr. Jarboe's deposition testimony; and while it is a part of the record, it was never assigned an Exhibit number by Judge Holmes. As such, Dr. Jarboe's deposition testimony is deemed Employer's Exhibit 2 (EX 2).

<i>Exhibit</i>	<i>Exam Date</i>	<i>Physician</i>	<i>Report Date</i>
<p>medical providers – Drs. Baron and Roberts – clearly believed that the process going on in his chest was due to residuals of his injury and complications thereof.</p> <p>I do believe that the evidence supports the fact that Mr. Perry had simple coal workers’ pneumoconiosis. Dr. Ferguson states that a few coal macules were seen in the tissues and also Dr. Naeye confirms the 1.5 cm silicotic nodule. I fee this is adequate pathological evidence to support a diagnosis of simple coal workers’ pneumoconiosis. On the other hand, there is abundant and compelling medical evidence that the mass in Mr. Perry’s right upper lung zone is a scar resulting from the injuries he sustained on 6/4/96 and which may well have incorporated some small bits of anthracotic pigment.</p> <p>I do not feel that there is evidence that Mr. Perry is totally and permanently disabled from a respiratory standpoint. There has been progressive improvement in his pulmonary function since his injury. The pulmonary function studies performed by Dr. Broudy on 12/3/99 were normal. They showed no evidence of restriction or obstruction. I feel that from a respiratory standpoint, Mr. Perry retains the functional respiratory capacity to do his last coal mining job or similar work in a dust free environment.</p> <p>Certainly, Mr. Perry may be disabled as a whole man because of the severe back injury that he sustained at the time of the rock fall. On the other hand, I find no evidence of a disabling condition of the respiratory system which has been caused by or substantially contributed to by the inhalation of coal dust or the presence of coal workers’ pneumoconiosis. Once again, I feel that Mr. Perry has simple coal workers’ pneumoconiosis, but it is my reasoned opinion that this is not causing a significant impairment or disability.</p>			
EX 2 <sup>5</sup>	4/4/01	Dr. Jarboe	4/4/01

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<sup>5</sup> It should be noted that this document, although a part of the record, was never assigned an Exhibit number by Judge Holmes. As such, Dr. Jarboe’s deposition testimony is deemed Employer’s Exhibit 2 (EX 2).

<i>Exhibit</i>	<i>Exam Date</i>	<i>Physician</i>	<i>Report Date</i>
<p>Dr. Jarboe's medical opinion is in the form of deposition testimony. Dr. Jarboe, who specializes in the field of pulmonary medicine, is licensed to practice medicine in both Kentucky and California. He is board certified in internal medicine, with a subspecialty in pulmonary disease. Dr. Jarboe is also a certified B reader. Upon review of the medical records provided to him, Dr. Jarboe prepared a 14-page report, dated February 25, 2001, which is attached and marked at Exhibit #1. Dr. Jarboe reiterated the findings he made in his report in that, upon review of Claimant's medical records, Mr. Perry does not have complicated pneumoconiosis. His basis is that there is fairly strong evidence that Mr. Perry did not have this mass in his chest until he sustained the injury to his back in September of 1996. This was followed by a pulmonary embolism, an infarction of the lung, which means death of the lung tissue. It was only after that that they began to see an abnormal shadow in the apex of the lung, especially on the right side. For these reasons, Dr. Jarboe feels that there's very strong evidence based on x-rays that were taken at the time he was injured, based on CT scans that were taken also around the same time, and follow-up x-rays that indicated he did not have this mass present at the time of his injury on September 4, 1996. Thus, I feel there's evidence that -- the evidence indicates that this mass is not complicated pneumoconiosis, but a residual scar from a pulmonary infarction.</p> <p>Mr. Perry does have evidence of simple coal workers' pneumoconiosis. However, Mr. Perry does not have a respiratory or pulmonary impairment that has been caused in whole or in part by the inhalation of coal mine, rock, or sand dust. This opinion is based on the December 1999 pulmonary function studies which were normal; so there was no evidence of restriction or obstruction, and thus, there was no evidence of an impairment which would</p> <p>be either a combined restriction and obstruction due to coal dust inhalation. So, I don't feel he had any evidence of impairment, he had no evidence that coal dust inhalation had affected his lungs physiologically.</p> <p>Mr. Perry retains the respiratory pulmonary capacity to perform his usual coal mine work.</p>			

The Benefits Review Board determined that the decision does not meet the substantial evidence standard established by Administrative Procedure Act (APA), 5 U.S.C. §557(c)(3)(A), as incorporated into the Act by 5 U.S.C. §554(c)(2), 33 U.S.C. §919(d) and 30 U.S.C. §932(a); and **Director, OWCP v. Congleton**, 743 F.2d 428, 7 BLR 2-12 (6th Cir. 1984).

The BRB also asks me to reconsider the qualifications of Dr. Westerfield, "who employer asserts is not a radiologist, in comparison to the qualifications of the other physicians in determining the weight accorded to his x-ray report." Id. I note that Dr. Westerfield is board certified in internal medicine and pulmonology, and is a Fellow in the American College of Chest Physicians, but is not board certified in radiology. DX 25, DX 28.

The BRB also asks me to consider, while several qualified physicians found the existence of simple and complicated pneumoconiosis, the decision failed to address the x-ray and CT scan readings which made no finding of simple or complicated pneumoconiosis. Director's Exhibits 25, 27; Employer's Exhibit 1.

The BRB also determined that although the decision treated Dr. Sargent's x-ray finding of a greater than four centimeter opacity as equivalent to a finding of complicated pneumoconiosis, "Dr. Sargent never stated that the ill-defined right upper lobe opacity of greater than four centimeters he found was complicated pneumoconiosis, but instead indicated: it was necessary to

rule out ‘neoplasm;’ to compare the x-ray with old films; to have additional studies; and to ‘correlate clinically.’” Id. and Director's Exhibit 17.

### **Pneumoconiosis**

#### *Existence of Pneumoconiosis*

The regulations define pneumoconiosis broadly:

(a) For the purpose of the Act, “pneumoconiosis” means a chronic dust disease of the lung and its *sequelae*, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or “clinical”, pneumoconiosis and statutory, or “legal”, pneumoconiosis.

(1) *Clinical Pneumoconiosis*. “Clinical pneumoconiosis” consists of those diseases recognized by the medical community as pneumoconioses, *i.e.*, the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers’ pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silico-tuberculosis, arising out of coal mine employment.

(2) *Legal Pneumoconiosis*. “Legal pneumoconiosis” includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For purposes of this section, a disease “arising out of coal mine employment” includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, “pneumoconiosis” is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

20 CFR § 718.201 (2002).

20 CFR § 718.202(a) (2002), provides that a finding of the existence of pneumoconiosis may be based on

- (1) chest x-ray,
- (2) biopsy or autopsy,
- (3) application of the presumptions described in §§ 718.304 (irrebuttable presumption of total disability/that a miner’s death was due to pneumoconiosis if there is a showing of complicated pneumoconiosis), 718.305 (not applicable to claims filed after January 1, 1982) or 718.306 (applicable only to deceased miners who died on or before March 1, 1978), or
- (4) a physician exercising sound medical judgment based on objective medical evidence and supported by a reasoned medical opinion.

Neither (2) or (3) above apply in this case. There is no evidence that Mr. Richardson has had a lung biopsy, and, of course, no autopsy has been performed. None of the presumptions apply, because the evidence does not establish the existence of complicated pneumoconiosis, has less than 15 years of work in coal mines/ filed his claim after January 1, 1982, and he is still living. In order to determine whether the evidence establishes the existence of pneumoconiosis, therefore, I must consider the chest x-rays and medical opinions. Absent contrary evidence, evidence relevant to either category may establish the existence of pneumoconiosis. In the face of conflicting evidence,

however, I must weigh all of the evidence together in reaching my finding whether the Claimant has established that he has pneumoconiosis. *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 211 (4<sup>th</sup> Cir. 2000).

#### *Complicated Pneumoconiosis*

In order to establish entitlement to benefits in a living miner's claim pursuant to 20 C.F.R. Part 718, claimant must establish that he suffers from pneumoconiosis, that the pneumoconiosis arose out of coal mine employment, and that the pneumoconiosis is totally disabling. See 20 C.F.R. §§718.3, 718.202, 718.203, 718.204. Failure to establish any of these elements precludes entitlement. *Trent v. Director, OWCP*, 11 BLR 1-26 (1987); *Gee v. W.G. Moore and Sons*, 9 BLR 1-4 (1986)(en banc); *Perry v. Director, OWCP*, 9 BLR 1-1 (1986)(en banc).

Section 718.304 provides an irrebuttable presumption that the miner is totally disabled due to pneumoconiosis if the miner is suffering from a chronic dust disease of the lung which:

- (a) When diagnosed by chest x-ray . . . yields one or more large opacities (greater than 1 centimeter in diameter) . . . ; or
- (b) When diagnosed by biopsy or autopsy, yields massive lesions in the lung; or
- (c) When diagnosed by means other than those specified in paragraph (a) and (b) of this section, would be a condition which could reasonably be expected to yield the results described in paragraph (a) or (b) of this section had diagnosis been made as therein described: Provided, however, that any diagnosis made under this paragraph shall accord with acceptable medical procedures. 20 C.F.R. §718.304(a)-(c). 20 C.F.R. §718.304(a)-(c); 30 U.S.C. §921(c)(3); *Gray v. SLC Coal Co.*, 176 F.3d 382, 21 BLR 2-615 (6th Cir. 1999); see *Director, OWCP v. Eastern Coal Corp. [Scarbro]*, 220 F.3d 250, 256, 22 BLR 2-93, 2-100 (4th Cir.2000); *Double B Mining, Inc. v. Blankenship*, 177 F.3d 240 (4th Cir. 1999); *Lester v. Director, OWCP*, 993 F.2d 1143, 17 BLR 2-114 (4th Cir. 1993).

I must, however, weigh together the evidence at subsections (a), (b) and (c) before determining whether invocation of the irrebuttable presumption has been established. *Gray*, supra; *Melnick v. Consolidation Coal Co.*, 16 BLR 1-31 (1991).

#### **Findings of Fact**

I note that a large rock fell on Mr. Perry while he was working in the coal mines. He was noted to be awake and alert at the hospital emergency room, however, he had extreme severe low back pain with dysesthetic pain of bi-lateral lower extremities. Lumbar spine films and x-rays demonstrated traumatic spondylolisthesis as well as bilateral transverse processes fractures of all lumbar vertebral bodies as well as several linear nondisplaced laminar fractures.

He was also noted to have retropleural hematoma as well as bilateral hemothoraces. Subsequent to that began experiencing right-sided chest pain and it was found that he had a diagnosis of a pulmonary embolism in spite of the Greenfield filter placement. He was subsequently anticoagulated and placed in the Intensive Care Unit.

He also underwent a posterior lumbar interbody fusion, L-5/S-1, with reduction of the fracture and posterior instrumentation. His postoperative course was complicated by the continuance of the foot pain.

The initial X-ray, taken from the supine position, was inconclusive. Therefore, William H. Johnstone, M.D. performed a CT Scan on September 4, 1996, which showed a moderately large (11 c.m.) hematoma on the right lung (DX 11, DX 12). While in the hospital, from September 4 to October 16, 1996, after it was established that he had a serious lung defect, he had almost daily X-

rays and CT scans of his chest. These reports consistently show densities in the Claimant's Right lung. See X-rays dated September 6, 12, 26, 28, 29, 30 (Two performed that day), October 1, 2, 3, 5, 6, 7, 8, 9, 16, and January 14, 1997. Pneumoconiosis is not established in any of these.

It was felt that Mr. Perry had problems in the right lung, but these were concentrations of fluid, traumatic hematomas and cysts, scar tissue, and even cancer.

Mr. Perry was referred to Dr. Westerfield by his attorney. On May 21, 1998, Dr. Westerfield performed an X-ray, which he read in June, 1998 as Positive for pneumoconiosis, type p/q, 1/1 profusion, and size A. The film quality is reported as "quality 2". He noted that the density in the right upper lung field may be a neoplasm rather than large pneumoconiotic opacity, and that granulomatous disease is also a consideration. DX 11, DX 12. I note that Dr. Wiot was not asked to render an opinion on this X-ray.

On August 26, Mr. Perry was examined by Dr. Baron and had an X-ray performed by Dr. Hoffnung, who noted less than optimal inspiration, resulting in some crowding of bronchovascular markings. When compared to Claimant's January 14, 1997 X-ray, Dr. Hoffnung noted that the previously described densities in the right hemithorax are again demonstrated, appearing similar to the prior exam. DX 11, DX 12. Dr. Wiot found that he could read the X-ray, but there was no evidence of pneumoconiosis. DX 29.

On September 2, 1998, Dr. Westerfield performed a second X-ray, which also showed that the Claimant has complicated pneumoconiosis. DX 11, DX 12. He determined that to a reasonable of medical probability, the Claimant's disease or condition is related to his work environment, which he had noted included coal mine employment. He determined "Within reasonable medical probability, any pulmonary impairment is caused in part by factors in patient's work environment (e.g., coal dust, chemicals)." DX 11, DX 12. Dr. Wiot did not read the X-ray.

On September 24, 1998 Dr. Miller took an X-ray which he read as showing ill defined densities in the right lung. DX 11, DX 12. Dr. Wiot considered the same X-ray as unreadable. DX 29. X-rays were also taken on September 25, 26 and two sets were taken on the 27th, 1998. DX 11, DX 12. All showed the density, but the reports did not comment on whether or not pneumoconiosis was present.. Dr. Wiot did not read the first two, but found one of the September 27 X-rays unreadable. DX 29, DX 38. These X-rays were taken when the Claimant was a patient at Wellmont Bristol Regional Medical Center. DX 11, DX 12. After a PET lung imaging scan showed the right upper lobe lesion, and after a CT scan also demonstrated "intense hypermetabolism" consistent with a neoplastic process; no evidence of mediastinal spread or spread elsewhere in the thorax identified, Mr. Perry patient was again referred to Dr. Roberts, his surgeon. After evaluation, Mr. Perry underwent a thoracotomy with wedge resection of right lower lobe nodule and right upper lobe nodule as well as Tm-Cut needle biopsy of the right upper lobe nodule. The testing revealed multiple fibrohistiocytic nodules associated with anthrasicotic material "consistent with coal worker's pneumoconiosis." Id. and DX 31. According to DrRoberts' report:

The subcutaneous tissue was divided and the serratus anterior was divided. The serratus was mobilized and spared and incision was made to about the fifth interspace. The intercostal muscles were divided and the lung was deflated but was firmly adherent. Careful gently dissection of the lung tissue from the chest wall was accomplished. We spent some time mobilizing the middle and lower lobes and most of the upper lobes. We were able to get the mass in question where we could biopsy this. There were several good discrete nodules that were in the posterior aspect of the lower lobe and we were able to wedge these out with

GIA stapling device and this fired, wedged out and sent for frozen section. It was very hard, but we were also able to do a second biopsy of the upper lobe in a similar fashion and sent these for frozen section and then the larger confluence of masses in the upper lobe, in this area, we were able to do multiple true cut biopsies in this area. They all grossly appeared to be very hard anthracotic nodules. Frozen section diagnosis was consistent with benign fibrohistiocytosis and his lung certainly had an anthracotic appearance of coal miners disease.

Id.

Initially, William H. Johnstone's, M.D. CT Scan dated September 4, 1996 showed a moderately large (11 c.m.) hematoma on right lung (DX 11, DX 12). I note that neither the CT Scan or the PET scan are considered as X-rays for evaluation under 20 CFR § 718.202(a)(1), but may be other "objective medical evidence" under 20 CFR §718.202(a)(4).<sup>6</sup> They are not subject to the specific requirements for evaluation of X-rays, and must be weighed with other acceptable medical evidence. *Melnick v. Consolidation Coal Co.*, 16 B.L.R. 1-31, 1-33-1-34 (1991).

On December 7, 1998, Dr. Ohriber, also a board certified "B" reader, found the X-ray positive for pneumoconiosis, type p/s, 1/1 profusion, and size A. He noted that the film quality was perfect. He did not have other X-rays to compare. DX 11. Dr. Wiot did not read this X-ray.

On January 29, 1999, Dr. Powell performed an examination for the Employer. He read his X-ray as positive for pneumoconiosis, type pq/t, 1/1 profusion, and size A and also noted excellent film quality He noted unilateral right pleural scarring consistent with a right thoracotomy and an elevated right hemidiaphragm calcification of infection. DX 11, DX 13, DX 27. Dr. Wiot did not read this X-ray.

In his deposition, Dr. Powell maintained that the X-ray disclosed pneumoconiosis and that the size was "A"; however, after he was referred to a report of Dr. Naeye, he stated that although lesions were more than a millimeter in size, they were not in the aggregate. DX 27, at 5- 6. When asked whether the Claimant has complicated pneumoconiosis, Dr. Powell responded, "he does not have the usual massive progressive fibrosis associated with coal worker's pneumoconiosis." Id. at 8. On cross examination, he reported that the lesion was "grater" [sic] than a centimetre but less than five centimeters. Id. at 10. He also stated that if he did not have Dr. Naeye's report, he would have, and indeed did, categorize the reading as complicated pneumoconiosis. Id at 10, 13. " His X-ray meets the radiographic criteria for complicated...." Id., 13.

In a letter dated October 8, 1999, Dr. Westerfield reported that Dr. Ferguson's microscopic interpretation is descriptive of progressive massive fibrosis and that the microscopic structures of progressive massive fibrosis is identical to that of coal nodules, but consists of a large quantity of the fibrotic nodules. According to Dr. Westerfield, there were enough coal nodules coalescing

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<sup>6</sup> A determination of the existence of pneumoconiosis may also be made if a physician, exercising sound medical judgment, notwithstanding a negative X-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in Sec. 718.201. Any such finding shall be based on objective medical evidence such as blood-gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion.

together to have the radiographic appearance of progressive massive fibrosis. The concern for lung cancer was valid because progressive massive fibrosis nodules can resemble lung cancer. In summary, it is Dr. Westerfield's opinion that the specimens of Mr. Perry's lung confirms his diagnosis of progressive massive fibrosis, complicated coal workers' pneumoconiosis. DX 28.

On November 11, 1999, Mr. Perry had an X-ray taken by A.R. Hudson, M.D. He read it as positive for pneumoconiosis, type p/q, 1/1 profusion and size B. DX 16. Reading the same X-ray, Dr. E. Nicholas Sargent found no evidence of pneumoconiosis. He did note a well defined right upper lobe density, more than four centimeters opacity. He noted that one must rule out a neoplasm. "Need additional studies." DX 17. He is a board certified radiologist "B" reader. DX 18.

On December 3, 1999, Mr. Perry was examined by Dr. Broudy. As noted earlier, the X-ray was read as positive for pneumoconiosis, type q/t, 1/1 profusion and size A. DX 25. In his report, Dr. Broudy speculated that the lesion would have been present even prior to injury. "If the opacity resulted from the injury itself rather than coal worker's pneumoconiosis." Id.

In a letter dated January 22, 2000 Richard Naeye, a board certified pathologist, rendered the following opinion:

This man may have impairments in lung function secondary to the trauma he sustained in 1996. If he is still very obese he is likely disabled, by a combination of direct damage caused by the 1996 trauma, multiple pulmonary arterial emboli, and the sleep apnea syndrome (often called the Pickwickian syndrome after the repeatedly falling asleep behavior of the fat boy in the Pickwick papers). The lesion that was resected from his right lung in 1998 is a silicotic nodule. It does not have any of the characteristic microscopic features of complicated coal worker's pneumoconiosis. If because of its size (5 x 2.5 x 2 cm) others wish to classify it as complicated CWP that would be a legal rather than a scientific or medical judgment. I cannot see how this silicotic nodule, resected or not, could have a measurable effect on lung function and thus be preventing this man from returning to work mining coal.

DX 28. Dr. Naeye had noted:

In 1997 a CT scan revealed a lesion in the lower part of this man's right upper lung lobe and in the adjacent area of his right lower lung lobe. It was 5 x 2.5 x 2 cm in its dimensions and charcoal-gray (not deep black) in color when it was excised on 9/24/98. Received for review are 7 glass slides with tissue removed from this lesion. The slides with this lesion are labeled 984613, Bristol Regional Medical Center. On microscopic examination it is a typical silicotic nodule that has grown over a number of years to the size it reached in 1998. Its center is comprised of old, hyalinized collagen with only a few birefringent crystals at those points where small amounts of black pigment have been trapped in the collagen. As one leaves this central area old granulation tissue appears with a small to moderate amount of admixed black pigment and many birefringent crystals of all sizes. At its periphery the granulation tissue is more recent in origin and the same mixture of small amounts of black pigment and birefringent crystals are present. Except at its hyalinized center, there are many undamaged blood vessels within the lesion. In this latter characteristic it in no way resembles the lesion of complicated coal worker's pneumoconiosis (CCWP) in which obliteration of blood vessels is a characteristic feature with resulting necrosis in the center of the lesion that resembles black ink. The lesion also does not fit the description of CCWP in another

important respect. It has not arisen against the background of many obvious anthracotic macules and micronodules which indicate that simple CWP long antedated its appearance.

Id.

In a letter dated February 21, 2000, Dr. Westerfield noted that he had reviewed the reports of Dr. Ferguson and Dr. Naeye. He reiterated that in his opinion, Mr. Perry has complicated pneumoconiosis. DX 28. He noted that the nodule specimen is “.5 x 2.5 x 2 cm, which by definition is Progressive Massive Fibrosis.” He also noted that Dr. Naeye’s concern of “undamaged blood vessels within the lesion” reflects the age of the process, not the lack of appropriate pathology. The tissue is from a forty seven year old man. In a few more years this mass would be larger and show more of the classical features of progressive massive fibrosis.” Moreover, regarding Dr. Naeye’s suggestion that Mr. Perry’s biopsy specimen has not arisen against a background of simple coal workers pneumoconiosis {,} one must remember that this pathological specimen is only a biopsy of the mass lesion, not the entire lung ( or even a lobe). Also, Mr. Perry’s chest radiographs show the appropriate background of coal macules with a profusion level of ½. “

Id.

In a deposition taken March 23, 2000, Dr. Westerfield reiterated his position that the Claimant has complicated pneumoconiosis, characterized by massive lesions at two places in the right lung. DX 28.

He was asked by the Employer to explain how it had progressed rapidly, Dr. Westerfield advised that there is “variability in the individual”. Id at 16. When asked whether the Claimant’s lung volume has improved, he advised that it was measured after an accident that crushed his ribs and that any studies have to account for the history. Id. at 16 - 18, 19-20.

In a letter also dated March 23, 2000, Dr Ferguson reported that he reviewed the slides taken by Dr. Nelson and reviewed Dr. Naeye’s report. DX 31. He speculated that Dr. Naeye had not read all of the slides because there were “confusing statements” in his report. Although Dr. Naeye measured the lesion as “5 x 2.5 x 2 cm”, Dr. Ferguson notes that:

We actually received three different specimens. The first of these was a 5 cm wedge of right lower lobe pulmonary parenchyma that contained a 1.5 cm well circumscribed dark gray mass. In addition, we received needle biopsies of an upper lobe lesion and an additional 1 cm resection of lower lobe pulmonary tissue that contained a separate and distinct 0.5 cm dark gray mass. So, rather than one lesion of 5 cm maximal dimension being present, it appears that at least three separate lesions are present ranging in size from 0.5 to 1.5 cm. At least two of these are palpable nodules measuring 0.5 and 1.5 cm in maximal dimension that, according to the surgical requisition are separate lower lobe lesions. In addition, there is a similar lesion of uncertain size but, measuring at least 0.5 cm, judging from the gross description of specimen #2, present in the right upper lobe. In addition to these palpable nodules in slide D of specimen #1, which represents pulmonary tissue adjacent to the palpable mass, two small coal dust macules are present.

Id.

He restated his opinion there is evidence of pneumoconiosis. Id.

In a letter dated April 7, Dr. Baron concluded that the Claimant has complicated pneumoconiosis. DX 31. He also objected the accusation made by Dr. Naeye that the Claimant is obese. He noted that Dr. Naeye is not a clinician.

In a report dated May 2, 2000, Dr. Wiot advises that he has reviewed certain records and that there is no evidence of pneumoconiosis in the record:

There is no evidence of coal worker s pneumoconiosis. Although most films are unreadable for evaluation of pneumoconiosis, the study of 09-30-96 which is a portable study shows a massive right pleural effusion. Subsequent films show insertion of a thoracostomy tube, which has been removed by 10-07-96. The series of films dated 10-16-96, 01-14-97 and 08-26-98 are important in the overall evaluation of this patient. The study of 10-16-96 shows evidence of loculated effusions and infiltrate present within the posterior segment of the right upper lobe, with associated air bronchograms indicating that it is an air space problem. The study of 01-14-97 shows resolution of the air space change, with thickening of the major fissure in its superior aspect and some pleural disease extending along the right lateral chest wall, but a definite improvement from 10-16-96. The study of 08-26-98 shows residual thickening of the superior aspect of the right major fissure, with a new ill-defined density in the posterior segment of the right upper lobe, which was not present on 01-14-97 and definitely smaller than it was on 10-16-96. This sequence of events in itself indicates that it is not a large opacity as was reported pathologically. The timing is totally inappropriate.

DX 29.

Dr. Wiot reviewed CT scans dated September 27, 1996, March 7, 1997 and June 2, 1998:

The CT scans show no small opacities to indicate the presence of coal worker s pneumoconiosis. The CT scan of 09-27-96 shows, in addition to pleural disease, pulmonary infiltrate involving the bases of the lungs as well as the upper lung fields with air bronchograms. This would indicate that this is an air space problem, not a large opacity. Of importance is the fact that between the 1996 studies and the 03-07-97 study, there has been a significant change in this process, and there is stranding extending to the right hilum and air bronchograms consistent with an inflammatory process. The study of 06-22-98 again shows significant change in this process. Although this process appears more solid in its character, the significant change which occurs between 1996, 1997 and 1998 would indicate that this is residual of a past inflammatory process and not the development of a large opacity. The process is too rapid for development of a large opacity and its character early on is totally against that.

In summary, neither the CT scans nor the chest xrays show any evidence of coal worker s pneumoconiosis. The changes within the right upper lobe are almost assuredly the residual of an inflammatory process which was present early in this patient s course, shown by the changes which occur over the interval.

Id.

On July 10, 2000, Dr. Wiot testified by deposition for the Employer. DX 38. He restated the position that Mr. Perry does not have simple pneumoconiosis. He relied in large part on his reading of CT scans:

...the CT scans show no nodules. I have never seen a patient who had a large opacity and had no evidence of simple coal worker's pneumoconiosis. Now, I recognize that you can have pathologically simple coal worker s pneumoconiosis at a minimal degree and we not see it radiographically, but the combination of three CT scans showing no evidence of simple coal worker s pneumoconiosis would be strongly against this being a large opacity

also. I don't ever remember seeing a large opacity in which I did not also see small nodules in the chest which were consistent with coal worker's pneumoconiosis.

Id. at 7-8. See also Id. at 16.

Dr. Thomas M. Jarboe testified by deposition for the Employer on April 4, 2001. Attached to the deposition is a medical report based on his review of the Claimant's medical records in connection with this matter. Dr. Jarboe concluded, within a reasonable degree of medical certainty, that Mr. Perry does have pneumoconiosis but does not have complicated pneumoconiosis:

To make this diagnosis, there must be a nodule that is 2 cm or greater in diameter in the lung tissues. It does appear that Claimant has a 1.5 cm silicotic nodule, but this does not constitute a diagnosis of complicated coal workers' pneumoconiosis. The other nodule lesion present and described by Dr. Ferguson was 0.5 cm in diameter. One may argue that the needle biopsies of the hard right upper lobe nodular lesion constitute the diagnosis of complicated pneumoconiosis, but I do not believe this is the case based on the following: (1) Most importantly, I do not feel the hard nodular lesions palpated by the surgeon and visualized on x-ray by numerous readers represents the lesion of complicated pneumoconiosis. The radiographic and clinical information clearly indicates that this lesion was not present when Mr. Perry was injured on 9/4/96. Had Mr. Perry had a lesion of progressive massive fibrosis, it would surely have been mentioned since it could have the appearance of a contusion and the physicians were looking for this type of abnormality. (2) There is also radiographic evidence that Mr. Perry did not have any space occupying mass in the right upper lobe at the time of his injury. A CT scan of 9/27/96 showed a pulmonary embolus in the right main pulmonary artery and volume loss in the right lung base, but no mention of a mass or nodular lesion in the right apex of the lung. (3) A ventilation perfusion scan of 9/12/96 was completely normal showing good ventilation and perfusion of the upper lung zones. However, when a lung scan was repeated on 1/14/97, there was a ventilation and perfusion defect in the right mid and upper lung zone. The lesion of progressive massive fibrosis could not have developed that rapidly. On the other hand, the medical evidence clearly indicates that Mr. Perry sustained a pulmonary embolus and infarction with hemorrhage into the lung which I feel caused the residual mass in the right upper lung zone. The final bit of radiographic evidence which tends to prove causation of the upper lobe nodular lesions is the description of the sequential CT scans by Dr. Wiot and also the sequential readings of the chest x-rays. These studies clearly showed that there was progressive improvement (although never total clearing) of the lesions in the chest. Progressive massive fibrosis would not improve once it appeared. (4) It is also quite clear that the Claimant's medical providers – Drs. Baron and Roberts – clearly believed that the process going on in his chest was due to residuals of his injury and complications thereof.

Id.

### **Evaluation of the Evidence**

#### *Pneumoconiosis*

It is evident that some of the physicians who read X-rays did not use the IL)/UC method to evaluate the Claimant's lung deficit. See reports of Drs. Johnstone, Gentry Miller, Foster, Hoffnung, Estes, Hutchinson and Whisnant. On the other hand, the readings are numerous and show that there is a large deficit in the lung on X-ray and CT scan. Whether an X-ray interpretation

which is silent as to pneumoconiosis should be interpreted as negative for pneumoconiosis, is an issue of fact. *Marra v. Consolidation Coal Co.*, 7 B.L.R. 1-216 (1984); *Sacolick v. Rushton Mining Co.*, 6 B.L.R. 1-930 (1984). An expert's report, which is silent as to a particular issue, is not probative of that issue. E.g. In a Black Lung case, it is proper for the ALJ to infer that an interpretation, which does not mention the a crucial element, as negative. *Billings v. Harlan #4 Coal Co.*, BRB No. 94-3721 BLA (June 19, 1997)(en banc)(unpublished). Contrary, *Sacolick v. Rushton Mining Co.*, 6 B.L.R. 1-930 (1984). However, in this case, I must place these X-rays in context.

For cases with conflicting x-ray evidence, the regulations specifically provide,

Where two or more X-ray reports are in conflict, in evaluating such X-ray reports consideration shall be given to the radiological qualifications of the physicians interpreting such X-rays.

20 CFR § 718.202(a)(1) (2002); *Dixon v. North Camp Coal Co.*, 8 B.L.R. 1-344 (1985); *Melnick v. Consolidation Coal Co.*, 16 B.L.R. 1-31, 1-37 (1991). Readers who are board-certified radiologists and/or B-readers are classified as the most qualified. The qualifications of a certified radiologist are at least comparable to if not superior to a physician certified as a B-reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211, 1-213 n.5 (1985). Greater weight may be accorded to x-ray interpretations of dually qualified physicians. *Sheckler v. Clinchfield Coal Co.*, 7 B.L.R. 1-128, 1-131 (1984).

In his Decision and Order, Judge Holmes discounted the opinions of Dr. Wiot because he alone had determined that there is no evidence of pneumoconiosis in this record.

The BRB determined that I should consider the fact that in addition to being a B-reader, Dr. Wiot was also a Board-certified radiologist as well as a professor of radiology. Director's Exhibit 29; see 20 C.F.R. §718.202(a)(1); *Fife v. Director, OWCP*, 888 F.2d 365, 13 BLR 2-109 (6th Cir. 1989); *Johnson v. Island Creek Coal Co.*, 846 F.2d 364, 11 BLR 2-161 (6th Cir. 1988); *Worhach v. Director, OWCP*, 17 BLR 1-105 (1993); *Melnick*, supra. After a review of the record, I note that fact.

It is clear that Dr. Wiot, Dr. Sargent and Dr. Ohriber are the only board certified radiologists and "B" readers in this record. In his Decision and Order, Judge Holmes discounted the opinions of Dr. Wiot because he alone had determined that there is no evidence of pneumoconiosis in this record.

Dr. Wiot read thirteen (13) X-rays, and of those, five (5) were considered to be "readable". He found no evidence of pneumoconiosis on any of them. XD 28, DX 38.

After a review of the record, I note that fact. It is evident that Dr. Wiot and Dr. Sargent are the most qualified X-ray readers in this record. However that does not mean that I must credit them with controlling weight.

An administrative law judge may utilize any reasonable method of weighing competing expert evidence. For example, in *Sexton v. Director, OWCP*, 752 F.2d 213 (6th Cir. 1985), the court held that the x-ray interpretation of an examining physician, whose credentials entailed several pages of achievements, was entitled to greater weight than that of a B-reader. even if the x-ray evidence is negative, medical opinions may establish the existence of pneumoconiosis. *Taylor v. Director, OWCP*, 9 B.L.R. 1-22 (1986). I am also not required to defer to the physicians with superior credentials. *Trumbo v. Reading Anthracite Co.*, 17 BLR 1-85, 1-88-89 (1993); *Clark v.*

**Karst-Robbins Coal Co.**, 12 BLR 1-149, 1-154 (1989); **Worley v. Blue Diamond Coal Co.**, 12 BLR 1-20, 1-23 (1988).

A chest x-ray may indicate the presence or absence of pneumoconiosis as well as its etiology. It is not utilized to determine whether the miner is totally disabled, unless complicated pneumoconiosis is indicated wherein the miner may be presumed to be totally disabled due to the disease. If a chest x-ray is positive for the existence of pneumoconiosis, then the x-ray report should indicate the size, type, and quantity of opacities in the lungs. The larger and/or more plentiful opacities indicate that the disease is at a more advanced stage. Sometimes, the x-ray report will be in narrative form. However, it will often be on a specific form designed by the Department of Labor.

In his deposition (DX 38), Dr. Wiot testified that there was a rapid change in the Miner's condition that occurred over a six (6) month period, from a reading of the CT scans, and that is his primary basis for a diagnosis of no pneumoconiosis. Id at 16.

A review of the record shows that Dr. Broudy, a B-Reader performed the most recent X-ray of record. He determined that it shows that Mr. Perry has pneumoconiosis. Because pneumoconiosis is a progressive and irreversible disease, it may be appropriate to accord greater weight to the most recent evidence of record, especially where a significant amount of time separates newer evidence from that evidence which is older. **Clark v. Karst-Robbins Coal Co.**, 12 B.L.R. 1-149 (1989)(en banc); **Casella v. Kaiser Steel Corp.**, 9 B.L.R. 1-131 (1986). This rule should not be mechanistically applied, however, in situations where the evidence would tend to demonstrate an "improvement" in the miner's condition. In **Cranor v. Peabody Coal Co.**, 22 B.L.R. 1-1 (Oct. 29, 1999) (en banc on recon.), the Board held that it was proper for the administrative law judge to give greater weight to the more recent evidence of record as the Sixth Circuit, in which jurisdiction the case arose, has held that pneumoconiosis is a "progressive and degenerative disease." See **Woodward v. Director, OWCP**, 991 F.2d 314 (6th Cir. 1993). The Board also cited to **Mullins Coal Co. of Virginia v. Director, OWCP**, 483 U.S. 135 (1987), reh'g. denied, 484 U.S. 1047 (1988) wherein the Supreme Court stated that pneumoconiosis is a "serious and progressive pulmonary condition." In weighing x-rays based upon the "later evidence" rule, it is the date of the study, and not the date of the interpretation, which is relevant. **Wheatley v. Peabody Coal Co.**, 6 B.L.R. 1-1214 (1984). Generally, it is proper to accord greater weight to the most recent x-ray study of record. **Clark**, supra; **Stanford v. Director, OWCP**, 7 B.L.R. 1-541 (1984); **Tokarcik v. Consolidation Coal Co.**, 6 B.L.R. 1-666 (1983).

However, even if the most recent x-ray evidence is positive, the administrative law judge is not required to accord it greater weight. Rather, the length of time between the x-ray studies and the qualifications of the interpreting physicians are factors to be considered. **McMath v. Director, OWCP**, 12 B.L.R. 1-6 (1988); **Pruitt v. Director, OWCP**, 7 B.L.R. 1-544 (1984); **Gleza v. Ohio Mining Co.**, 2 B.L.R. 1-436 (1979). The Board has indicated that a seven month time period between x-ray studies is sufficient to apply the "later evidence" rule, but that five and one-half months is too short a time period. **Tokarcik**, supra; **Stanley v. Director, OWCP**, 7 B.L.R. 1-386 (1984). However, in **Aimone v. Morrison Knudson Co.**, 8 B.L.R. 1-32 (1985), the Board held that it was proper for the administrative law judge not to apply the "later evidence" rule where eight months separated the dates of the x-ray studies.

I note that Dr. Broudy's X-ray (DX 25), which he read as positive for complicated pneumoconiosis was taken more than a year after that of Dr. Sargent and more than two years after the August 26, 1998 X-ray that Dr. Wiot read as negative (DX 29, 38). Dr. Wiot determined that X-rays dated September 24, 26 and 27, 1998 were unreadable Id.

A judge may consider the number of interpretations on each side of the issue, but not to the exclusion of a qualitative evaluation of the x-rays and their readers. **Woodward**, 991 F.2d at 321. The Board has held that an administrative law judge is not required to defer to the numerical superiority of x-ray evidence, **Wilt v. Wolverine Mining Co.**, 14 B.L.R. 1-70 (1990), although it is within his or her discretion to do so, **Edmiston v. F & R Coal Co.**, 14 B.L.R. 1-65 (1990). I note that of the X-rays taken after Dr. Wiot read the August 26, 1998 X-ray, Dr. Westerfield, Powell and Hudson submitted unqualified readings of both pneumoconiosis and complicated pneumoconiosis. DX 11, DX 12, DX 13, DX 16, DX 27 and DX 28.

Dr. Sargent read an X-ray taken on November 12, 1999 as negative for pneumoconiosis. DX 17. However, he noted a 4 centimeter density in the right lobe in the same place that all of the others had found pneumoconiosis.

Of the six (6) B readers who have read X-rays in this file, four have determined that there is evidence of pneumoconiosis in this record and two have not found any evidence of pneumoconiosis. Of the B -readers who have found pneumoconiosis, three (3) have diagnosed it as complicated: Drs. Broudy, Westerfield and Ohriber. DX 11, DX 12, DX 25, and DX 28.

A pulmonary disease may constitute statutory pneumoconiosis if it is significantly related to or aggravated by dust exposure in coal mine employment. The legal definition of pneumoconiosis is broad and may encompass more respiratory or pulmonary conditions than those specifically, clinically diagnosed in a medical opinion. For example, a physician may conclude that the miner suffers from asthma which is related to his coal dust exposure. Although the physician did not specifically state that the miner suffered from pneumoconiosis or black lung disease, the respiratory condition which he diagnoses is related to coal dust exposure and, therefore, is supportive of a finding of legal pneumoconiosis.

The Fourth Circuit has issued a number of decisions addressing broad definition of pneumoconiosis in the regulation. "Pneumoconiosis" is a legal term defined by the Act and the judge "must bear in mind when considering medical evidence that physicians generally use 'pneumoconiosis' as a medical term that comprises merely a small subset of the afflictions compensable under the Act." Thus, an administrative law judge should review evidence in light of the much broader legal definition. **Barber v. Director, OWCP**, 43 F.3d 899 (4th Cir. 1995). See also **Dehue v. Director, OWCP**, 65 F.3d 1189 (4th Cir. 1995); **Hobbs v. Clinchfield Coal Co.**, 45 F.3d 819 (4th Cir. 1995) ("a medical diagnosis of no pneumoconiosis is not equivalent to a legal finding of no pneumoconiosis"). In **Richardson v. Director, OWCP**, 94 F.3d 164 (4th Cir. 1996), the court reiterated that "[c]linical pneumoconiosis is only a small subset of the compensable afflictions that fall within the definition of legal pneumoconiosis under the Act" and that "COPD, if it arises out of coal mine employment, clearly is encompassed within the legal definition of pneumoconiosis, even though it is a disease apart from clinical pneumoconiosis." The court also held that the Director's "stipulation," that the miner suffered from legal pneumoconiosis arising from coal dust exposure at the time of death, was binding notwithstanding a lack of medical evidence in the record to support the stipulation. See also **Cornett v. Benham Coal, Inc.**, 227 F.3d 569 (6th Cir. 2000) (the court emphasized the distinction between legal and medical pneumoconiosis; a

miner's exposure to coal mine employment must merely contribute "at least in part" to his pneumoconiosis); *Kline v. Director, OWCP*, 877 F.2d 1175, 1178 (3d Cir. 1989); *Brown v. Director, OWCP*, 851 F.2d 1569 (11th Cir. 1988), app. dismissed, 864 F.2d 120 (11th Cir. 1989); *Phipps v. Director, OWCP*, 16 B.L.R. 1-100 (1992) (recognizing the distinction between legal and clinical pneumoconiosis); *Biggs v. Consolidation Coal Co.*, 8 B.L.R. 1-317, 1-322 (1985).

The new regulatory provisions at 20 C.F.R. § 718.201 contain a modified definition of "pneumoconiosis" and they provide the following:

(a) For the purposes of the Act, 'pneumoconiosis' means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or 'clinical', pneumoconiosis and statutory, or 'legal', pneumoconiosis.

(1) Clinical Pneumoconiosis. 'Clinical pneumoconiosis' consists of those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.

(2) Legal Pneumoconiosis. 'Legal pneumoconiosis' includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(3) For purposes of this section, a disease 'arising out of coal mine employment' includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

20 C.F.R. § 718.201 (Dec. 20, 2000).

Weighing all of the evidence, to any reasonable degree of probability or certainty, the evidence shows that the Miner had at least simple pneumoconiosis. As I had said previously, a review of the entire record shows that all of the early diagnoses were incorrect. Even Dr. Jarboe notes that all of the readers who had failed to diagnose pneumoconiosis had erred. CX 1 at 19 - 22. Dr. Baron was the first physician to consider the claimant has a restrictive lung disease. He performed several physical examinations and performed appropriate pulmonary function testing. The controversy regarding the reading of initial X-rays and CT scans led to the need for the biopsy.

I attribute little weight to the readings of Drs. Johnstone, Gentry Miller, Foster, Hoffnung, Estes, Hutchinson and Whisnant. I note that the record shows that all found large densities in the right lung, but none rendered a diagnosis of pneumoconiosis.

I give no weight to the reports of Drs. Goldman, Templin, Kennedy and Patel on this issue.

I am directed to whether the Claimant's chest X-ray obtained during 1996 hospitalization was "normal," that the X-ray evidence consistently showed that claimant had a clear left lung inconsistent with a finding of simple or complicated pneumoconiosis, and that the administrative law judge failed to consider that the scarring on x-rays demonstrated a progression in the effects of claimant's injury and the development of the embolism in his right lung. I reject this contention.

I accept that a biopsy is a more defined test to determine the presence of pneumoconiosis than are X-rays and CT scans. *Terlip v. Director, OWCP*, 8 BLR 1-363 (1985).<sup>7</sup> I do not accept that the September 4, or for that matter that any of the 1996 and 1997 X-rays were “normal” as argued by the Employer and Dr. Wiot. Actually, The September 4, 1996 X-ray was not read for pneumoconiosis and the Employer’s reader, Dr. Wiot, determined that it is unreadable. DX 29. A CT scan was performed that day and it showed that there was a moderately large (11 c.m.) hematoma on right lung (DX 11, DX 12). Later, all of the initial X-ray and CT readings were proven to be incorrect. It was not until Dr. Westerfield diagnosed pneumoconiosis, that it was even considered as a cause for the densities that appeared on the X-rays and scans. The record shows that there were five (5) CT and lung scans performed prior to the biopsy. All showed large densities were present in the right lung. DX 11 and DX 12. None of the alleged diagnoses were proven.

After all of the evidence has been reviewed, Dr. Wiot and Dr. Sargent are the only readers who now fail to diagnose pneumoconiosis. To accept their opinions, one must reject the findings found on X-ray and reject even the opinions of Employer physicians. Clearly their opinions are contrary to full weight of the evidence and must be discounted. If Dr. Wiot’s opinions are the basis for the initial premise that there was no pneumoconiosis, then all constructions based on that premise are equally faulty. Even Dr. Naeye and Dr. Jarboe had to admit that the biopsy evidence is conclusive that there is pneumoconiosis in the record. DX 27; EX 1, EX 2.

Dr. Powell presents conflicted testimony. He recanted his position after accepting Dr. Naeye’s opinions in toto. As I have discounted them, I discount the altered opinion. I have discretion to accord less probative value to a physician’s opinion which is inconsistent with his or her earlier report or testimony. *Hopton v. U.S. Steel Corp.*, 7 B.L.R. 1-12 (1984). However, I accept that his initial opinion, that the evidence showed that the Claimant has complicated pneumoconiosis.

I accord significant weight to Dr. Broudy’s reading as to the presence of pneumoconiosis. His X-ray is the most recent of record. EX 1, EX 2. I note also that the preponderance of the recent X-rays are also positive for pneumoconiosis.

I accord significant weight to the reading of Dr. Westerfield, who read the May 21, 1998 X-ray as positive for pneumoconiosis. DX 11, DX 12. I also accord significant weight to the opinions of Dr. Baron, the Claimant’s treating pulmonologist, who determined that the Claimant had a restrictive impairment on May 7, 1997. DX 11.

I attribute the most weight to the biopsy and the reports of Dr. Roberts and Ferguson.

**Therefore**, I find that the Claimant has established that he has pneumoconiosis.

*Complicated Pneumoconiosis*

In his report, Dr. Naeye stated,

If because of its size (5 x 2.5 x 2 cm) others wish to classify it as complicated CWP that would be a legal rather than a scientific or medical judgment.

DX 28.

Dr. Broudy marked the size as “A”. Box 2C of the X-ray report contains the letters O, A, B, and C. If the physician checks A, B, or C, the x-ray yields evidence that the miner suffers from

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<sup>7</sup> Biopsy evidence, like autopsy evidence, is more reliable indicator as to the presence or absence of pneumoconiosis.

complicated pneumoconiosis. 20 C.F.R. §§718.102(b), 718.202(a)(1). I accept that this means that the lesion was at least one centimeter in size. Dr. Broudy rendered the following diagnoses: (1) radiographic and pathological findings suggestive of complicated coal workers' pneumoconiosis; Dr. Hudson also noted that the Claimant had complicated pneumoconiosis, Size B. Dr. Powell and Dr. Ohriber find Size A consistent with Dr. Broudy. In fact, their opinions are all exactly the same as Dr. Westerfield's first reading (the May 21, 1998 X-ray), and are similar to the second..

Dr. Westerfield, a board certified pulmonologist, determined that the Claimant has complicated pneumoconiosis. He examined the Claimant, and read two X-rays and testified that the Claimant has a lesion that is three centimeters in size. He noted that the coal macules combine with silica, to form the coagulated density in the right lung.

It is probably because there is more silica involved than pure coal dust – silica is a lot more fibrogenic which is going to cause continued tissue reaction over time.

DX 28.

I note that the prior decision mis-characterized the report of Dr. Sargent as supportive of complicated pneumoconiosis, when Dr. Sargent diagnosed neither simple nor complicated pneumoconiosis by x-ray. I reject Dr. Sargent's conclusions as they are contrary to the full weight of the evidence. Even Dr. Naeye and Dr. Jarboe had to admit that the biopsy evidence is conclusive that there is pneumoconiosis in the record. I do note that he reports the presence of a large mass, however, in the same areas in which pneumoconiosis was discovered on biopsy. I accept that this is consistent with the readings of Drs. Westerfield, Ohriber, Powell, Hudson and Broudy.

I note that all of the above, with the exception of Dr. Hudson are "B" readers. I note that Dr. Ohriber is a board certified radiologist.

I note that the Regulations specifically refer to the term, "silicosis". Dr. Naye described the slide as "a typical silicotic nodule...Its center is comprised of old, hyalinized collagen with only a few birefringent crystals at those points where small amounts of black pigment have been trapped in the collagen. As one leaves this central area old granulation tissue appears with a small to moderate amount of admixed black pigment and many birefringent crystals of all sizes. At its periphery the granulation tissue is more recent in origin and the same mixture of small amounts of black pigment and birefringent crystals are present." DX 28.

In his deposition, Dr. Jarboe determined that the Claimant has established that he has pneumoconiosis, but that it is not complicated pneumoconiosis. EX 1. He credits Dr. Ferguson's finding to determine that there is pneumoconiosis present. Id However, Dr. Jarboe does not accept that the pneumoconiosis deposits are large enough to merit a diagnosis of complicated pneumoconiosis:

After all, he had a one centimeter nodule, he had a one and a half centimeter silicotic nodule, so he--I don't think there's any question that this man has anthracosilicosis, but when one looks at the overall evidence the degree of pneumoconiosis must be extremely mild and the amount of nodulation, that is the macules and the micronodules in the lung must be extremely small.

Id at 19.

He noted that pathologically, to render a diagnosis of complicated pneumoconiosis, the lesion must be two (2) centimeters or larger. Id at 11.

Complicated pneumoconiosis may be proven by x-ray evidence only if the x-ray evidence, which must be weighed, reveals one or more large opacities (greater than one centimeter in

diameter), classified as category A, B, or C. 30 U.S.C. §921(c)(3)(A); 20 C.F.R. §§410.418(a), 718.304(a). Complicated pneumoconiosis may be established by autopsy or biopsy evidence, if such evidence establishes massive pulmonary lesions. 30 U.S.C. §921(c)(3)(B); 718.304(b).<sup>8</sup> Finally, a provision is made for diagnosis of complicated pneumoconiosis by other means, if the condition diagnosed would yield results similar to those described above if diagnosed by x-ray, autopsy or biopsy. 30 U.S.C. §921(c)(3)(C); 20 C.F.R. §§410.418(c), 718.304(c). The Board has construed this standard strictly in several cases. See *Lohr v. Rochester & Pittsburgh Coal Co.*, 6 BLR 1-1264 (1984); *Clites v. Jones & Laughlin Steel Corp.*, 2 BLR 1-1019 (1980); *Gaudiano v. United States Steel Corp.*, 1 BLR 1-949 (1978).

Drs. Naeye and Powell take the same position as Dr. Jarboe, that the disease process had developed too rapidly to be complicated pneumoconiosis. Dr. Westerfield advised that there is “variability in the individual”. DX 28 at 16. Dr. Jarboe related that at first, the physicians were not attempting to evaluate for pneumoconiosis the Claimant as his primary concern was the crush injury. Later he was evaluated for cancer. In his deposition, he notes that the early X-ray readings and CT scan readings were wrong, as the Claimant actually had what he now characterizes as simple pneumoconiosis. CX 1 at 19 - 21. He admitted that only Dr. Baron had been correct as to a diagnosis of pneumoconiosis. Id at 21. The premise that the disease process is too rapid is based on the allegation that there had been negative findings that had ruled out pneumoconiosis prior to biopsy. I already have discussed that I discount Dr. Wiot’s readings and his testimony, as his opinion is contrary to the weight of the evidence. Actually, The May 21, 1998 X-ray read by Dr. Westerfield was the first to identify pneumoconiosis as a diagnosis. Dr. Wiot was not given this X-ray, or any of the more recent X-rays to read. He had an incomplete record as to the disease process. The most recent reading, by Dr. Broudy is exactly the same as that of Dr. Westerfield’s reading of the May 21, 1998 X-ray. The notion that these experts had a complete notion of the disease process is not proven. Therefore, I discount the argument regarding the speed of the disease process as mere speculation.

Dr. Naeye argues that absent a finding of observation of obliteration of blood vessels, one can not diagnose complicated pneumoconiosis. Dr. Westerfield notes that Dr. Naeye’s concern of “undamaged blood vessels within the lesion” reflects the age of the process, not the lack of appropriate pathology. The tissue is from a forty seven year old man. In a few more years this mass would be larger and show more of the classical features of progressive massive fibrosis.” Moreover, regarding Dr. Naeye’s suggestion that Mr. Perry’s biopsy specimen has not arisen against a background of simple coal workers pneumoconiosis {,} one must remember that this pathological specimen is only a biopsy of the mass lesion, not the entire lung ( or even a lobe). Also, Mr. Perry’s chest radiographs show the appropriate background of coal macules with a profusion level of ½. “DX 28.

In *Double B Mining, Inc. v. Blankenship*, 177 F.3d 240, 244 (4th Cir.1999), the Court determined that an ALJ must render an equivalency finding supported by substantial evidence if Subsection A is not used.

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<sup>8</sup> Section 410.418(b) also states that a biopsy or autopsy will be accepted as evidence of complicated pneumoconiosis if the histological findings establish simple pneumoconiosis and progressive massive fibrosis. Section 718.304(b) does not contain this additional provision.

One may infer that Dr. Jarboe argues that a lesion must be at least two (2) centimeters in size to make a finding that on X-ray it would measure one centimeter. However, he notes that:

- (1) The claimant has a lesion measuring 1.5 centimeters, CX 2. CX 1
- (2) X-ray evidence shows that there is sufficient size to establish complicated pneumoconiosis. CX 1, at 12.
- (3) CT evidence shows a lesion large enough to be complicated pneumoconiosis. CX 1 at

28.

His position is that because of the rapid disease process, composition of the lesion does not represent complicated pneumoconiosis. Id.

Dr. Powell's testimony is conflicted. Dr. Powell testified that his opinion was influenced by Dr. Naeye's report. Whereas Dr. Powell initially determined that the X-ray disclosed pneumoconiosis and that the size was "A"; however, after he was referred to a report of Dr. Naeye, he stated that although lesions were more than a millimeter in size, they were not in the "aggregate". DX 27, at 5- 6.

Although Dr. Naeye is eminently qualified, I discount his logic and his conclusion because:

- (1) Despite his extensive knowledge, he is unable to determine "legal" pneumoconiosis and wrongly dismisses the presence of silica on the slide as incompetent to legally constitute the basis for pneumoconiosis under case law and the regulations.
- (2). Although he determines that there insufficient data from the slide material, Dr. Ferguson was in a better position to know what was in the slide material, and this is a major premise that is the basis for the remainder of Dr. Naeye's conclusion. The evidence shows, that to the contrary, there were three different specimens.

The first of these was a 5 cm wedge of right lower lobe pulmonary parenchyma that contained a 1.5 cm well circumscribed dark gray mass. In addition, we received needle biopsies of an upper lobe lesion and an additional 1 cm resection of lower lobe pulmonary tissue that contained a separate and distinct 0.5 cm dark gray mass. So, rather than one lesion of 5 cm maximal dimension being present, it appears that at least three separate lesions are present ranging in size from 0.5 to 1.5 cm. At least two of these are palpable nodules measuring 0.5 and 1.5 cm in maximal dimension that, according to the surgical requisition are separate lower lobe lesions. In addition, there is a similar lesion of uncertain size but, measuring at least 0.5 cm, judging from the gross description of specimen #2, present in the right upper lobe. In addition to these palpable nodules in slide D of specimen #1, which represents pulmonary tissue adjacent to the palpable mass, two small coal dust macules are present.

DX 31.

- (3). A reading of Dr. Naeye 's report shows that he wrongly assumes that there is no history of complaints of coal workers' pneumoconiosis prior to the date of injury. The record shows that Mr. Perry testified that he had breathing problems prior to the injury (Tr at 16) and told his treating physicians that he had a history of breathing problems (DX 11 and DX 12).

- (4). Although Dr. Naeye offers the testimony regarding blood vessel obliteration, the record shows that he did not examine the entire slide material, and that the entire allegation is not substantiated. The statute and regulations do not set forth such a standard. In order to

completely accept this allegation, some showing of demonstrable reliability is warranted *Cornett v. Benham Coal, Inc.*, 227 F.3d 569 (6th Cir. 2000).

(5) If Dr. Naeye relied on the 1996 to 1998 X-rays abs CT scans for the formulation of his rationale, he reported that a 1997 CT scan revealed a lesion in the lower part of Claimant's right upper lung lobe and in the adjacent area of his right lower lung lobe as the basis for his theory. DX 27. However, Again, Dr. Ferguson reported that there were three different specimens, ranging in size from 0.5 to 1.5 cm. Dr. Ferguson further reported that at least two of these specimens are palpable nodules measuring 0.5 and 1.5 cm in maximal dimension that, according to the surgical requisition, are separate lower lobe lesions. Additionally, Dr. Ferguson reported that there is a similar lesion of uncertain size, but measuring at least 0.5 cm, judging from the gross description of specimen #2, present in the right upper lobe. In addition to these palpable nodules in slide D of specimen #1, which represents pulmonary tissue adjacent to the palpable mass, two small coal dust macules are present.

(6) Dr. Roberts was the attending surgeon who performed the biopsy and he noted that the materials excised grossly appeared to be very hard anthracotic nodules. I am directed by the Board that Dr. Roberts did not diagnose the existence of complicated pneumoconiosis, but only found multiple fibrohistiocyctic nodules associated with anthracosilicotic material *consistent with* coal workers' pneumoconiosis. I accept this observation. As he is in the best position to see the materials, I attribute significant weight to this statement. Dr. Naeye minimized the appearance of the specimen, in essence stating, to be complicated pneumoconiosis, it had to be black in color, rather than gray, and I discount his opinion in part for this reason.

(7) Dr. Ferguson also inspected the entire slide material and is in a better position to perform the evaluation. Greater weight may be accorded that opinion which is supported by more extensive documentation over the opinion which is supported by limited medical data. *Sabett v. Director, OWCP*, 7 B.L.R. 1-229 (1984). An opinion may be given less weight where the physician did not have a complete picture of the miner's condition. *Stark v. Director, OWCP*, 9 B.L.R. 1-36 (1986).

I must discount Dr. Naeye's opinions regarding the presence of complicated pneumoconiosis as a result. Therefore, I attribute more weight to Dr. Powell's written report and X-ray report than I do to his deposition testimony and "final" opinion, which I completely discount.

As to the allegation that the X-ray findings are the accumulation of scar tissue, the biopsy found pneumoconiosis and silica by all accounts and therefore, this theory is not substantiated. I also base this because, as I have stated before, both Dr. Naeye and Jarboe rely on a false premise and history provided in part by the X-ray and CT scan readings of Dr. Wiot. Dr. Wiot fails to find even pneumoconiosis, despite the biopsy evidence, and which is contrary to Dr. Naeye's and Jarboe's contentions. Even Dr. Jarboe notes that all of the readers who had failed to diagnose pneumoconiosis had erred. CX 1 at 19 - 22.

Dr. Jarboe also argues that in order to find that Mr. Perry has complicated pneumoconiosis, a restrictive component must be proved. Dr. Westerfield testified that there was no change in the pulmonary function studies, dated December 12, 1996 and December 3, 1997. He testified that the results of the 1998 pulmonary function studies showed some improvement, but he also stated that

absolute numbers may be skewed since Mr. Perry is measured at 2 inches taller and 30 pounds heavier in the 1998 report. When comparing these results to Claimant's 1999 studies, Dr. Westerfield acknowledged that the raw numbers were higher than the 1996 and 1998 studies; however, Dr. Westerfield stated that a more sensitive study would be diffusing capacity for exercise study because spirometry shows improvement. Dr. Westerfield reiterated his position that the Claimant has complicated pneumoconiosis, characterized by massive lesions at two places in the right lung. DX 28.

He was asked by the Employer to explain how it had progressed rapidly, Dr. Westerfield advised that there is "variability in the individual". Id at 16. When asked whether the Claimant's lung volume has improved, he advised that it was measured after an accident that crushed his ribs and that any studies have to account for the history. Id. at 16 - 18, 19-20.

Dr. Baron had determined that Mr. Perry had a restrictive component in 1997 and when all others had mis-diagnosed the Claimant. He has been a treating physician since the Claimant was hospitalized in 1996. He has been the referring physician to Dr. Roberts and to Dr. Ferguson. His opinion is entitled to greater weight than that of Dr. Jarboe, who has seen the Claimant on only one occasion, and has only the records to access the patient's history and the progression of the disease process.

But more importantly, despite the assertion by Dr. Jarboe, the regulations do not require a restrictive component. In *Warth v. Southern Ohio Coal Co.*, 60 F.3d 173 (4th Cir. 1995), the Fourth Circuit held that, for purposes of entitlement to benefits under the Act, chronic obstructive lung disease is encompassed in the legal definition of pneumoconiosis. Thus, the assumption by a physician that pneumoconiosis causes a restrictive impairment, rather than an obstructive impairment, is erroneous and undermines his conclusions. But see *Stiltner v. Island Creek Coal Co.*, 86 F.3d 337 (4th Cir. 1996), *reh'g. denied*, 86 F.3d 337 (4th Cir. 1996) (a physician's opinion should not be discredited merely because he states that coal dust exposure would "likely" cause a restrictive, as opposed to obstructive, impairment). Similarly, the Board has held that an obstructive impairment, without a restrictive component, may be considered regulatory pneumoconiosis. *Heavilin v. Consolidation Coal Co.*, 6 B.L.R. 1-1209 (1984). Moreover, the Board has held that pulmonary function studies are not diagnostic of the presence or absence of pneumoconiosis. *Burke v. Director, OWCP*, 3 B.L.R. 1-410 (1981).

Therefore, I discount the opinions of Drs. Naeye and Jarboe that the Claimant has not shown that he has complicated pneumoconiosis. I also find that it is improbable that Dr. Naeye, holding himself out as a leader in the field, should not know the nature of "legal" pneumoconiosis and that silica can be a part of the definition. Employer contends that Judge Holmes had no reason to question the validity of these doctors' opinions, in light of the fact that the evidence from Dr. Wiot and hospital reports from claimant's 1996 injury, which resulted in a pneumothorax and embolism, showed no evidence of complicated or simple pneumoconiosis in 1996. I have determined that Dr. Wiot and Dr. Sargent were incorrect in diagnosis. I also find that they were incorrect in relating a history of no pneumoconiosis. Dr. Roberts and Dr. Ferguson found pneumoconiosis in the lung biopsy. X-ray and CT evidence are circumstantial, whereas biopsy evidence constitutes direct proof.

Because I do not accept that Dr. Naeye or Dr. Jarboe have established a point of comparison, I also reject their opinions that the lesions were created too quickly to be complicated pneumoconiosis. Again, this is based in part on an assumption that Dr. Wiot was correct in his

diagnosis. I find that he was not. The Claimant had a crush injury. The primary emphasis was on resolving the immediate problem. The CT scans to which Dr. Wiot refers in retrospect were not an accurate indication that the Miner had pneumoconiosis. I discount any assertion on the basis of readings by Dr. Wiot, who did not diagnose even simple pneumoconiosis.

For the same reason, I do not accept Dr. Broudy's testimony that "[i]f the large opacity was not present at the time [of the accident] then it would imply that the opacity resulted from the injury, rather than coal workers' pneumoconiosis." This is based on the false assumption that Dr. Wiot was correct. It also improperly discounts the findings of Dr. Ferguson and Dr. Roberts that there were coagulated crystals. However, I do credit his X-ray report.

Moreover, I do not accept the notion that the Claimant *had* to prove that he had pneumoconiosis prior to injury. A review of the regulation shows that the Claimant has met his burden of proving that he had pneumoconiosis by force of the full weight of the evidence. That requirement is not part of the regulatory scheme to determine the existence of complicated pneumoconiosis. Moreover, I do not accept that the Employer has shown that the Claimant did not have pneumoconiosis prior to the accident. A party making a bald assertion has a duty to prove it by competent evidence. I do not accept that this is proved.

I credit Dr. Broudy's presentation in part, but reject any conclusion regarding the timing of the process and the presence of scarring for reasons set forth above.

I find Dr. Westerfield's reliance on the reports of Dr. Roberts and Dr. Ferguson to be well placed. I find that his reasoning is based on a complete record. A "documented" opinion is one that sets forth the clinical findings, observations, facts, and other data upon which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's work and social histories. *Hoffman v. B&G Construction Co.*, 8 B.L.R. 1-65 (1985); *Hess v. Clinchfield Coal Co.*, 7 B.L.R. 1-295 (1984); *Justus v. Director, OWCP*, 6 B.L.R. 1-1127 (1984). A "reasoned" opinion is one in which the administrative law judge finds the underlying documentation and data adequate to support the physician's conclusions. *Fields*, *supra*. Indeed, whether a medical report is sufficiently documented and reasoned is for the judge as the finder-of-fact to decide. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989)(en banc). As a board certified pulmonologist, Dr. Westerfield is qualified to diagnose complicated pneumoconiosis. And I accept that his rendition of the facts is more accurate than those of Dr. Jarboe and Naeye, who rely in part on a premise provided by Dr. Wiot, who does not find even simple pneumoconiosis in this record. Therefore, I find Dr. Westerfield's logic more rational than that of either Dr. Naeye and Dr. Jarboe.

I find that Dr. Baron also justifiably relied on the biopsy evidence, recent X-rays, as well as his own testing and observations. He is a treating physician and has had the opportunity to evaluate the claimant after numerous physical examinations. He also has had the opportunity to read and evaluate the other medical reports. The Claimant's condition was complicated by the occurrence of the crush injury. Although none of the other physicians had noted that the breathing deficit and the presence of densities on X-ray and scans may have come from a separate breathing disorder, his diagnosis must be credited. His office notes show that Mr. Perry complained of shortness of breath and that at time he had produced sputum. He was the first to diagnose a restrictive component. All the pulmonary function studies he performed are not dispositive and are questionable, but I accept that a restrictive component is established, and that impeaches Employer's contentions that the

Claimant did not have one. I accept that there is also an obstructive component to the impairment. In *Adamson v. Director, OWCP*, 7 B.L.R. 1-229 (1984), a treating physician's opinion based only upon a positive X-ray interpretation and claimant's symptomatology was deemed sufficiently documented. Dr. Baron has a complete record and his opinions are substantiated by the testing performed by Dr. Roberts and Dr. Ferguson. The evidence shows that three separate portions of the Miner's right lung bear large lesions, to any reasonable degree of probability, the same that were identified by the X-rays of Dr. Westerfield, Hudson, Powell, and Broudy.

I also credit the opinion of Dr. Hudson, who substantiates the opinions rendered by Dr. Baron and Dr. Westerfield..

Again, I note that the more recent testing substantiates that Dr's. Baron, Westerfield, Hudson and Ferguson are correct. The most recent X-rays show in preponderance that there is complicated pneumoconiosis and that it at a size "A" if not greater.

**Therefore**, I find to a reasonable degree of certainty that the X-ray evidence that shows the size of the pneumoconiosis as "A" must be credited. 30 U.S.C. §921(c)(3)(A); 20 C.F.R. §§410.418(a), 718.304(a). See also 20 C.F.R. §§718.102(b), 718.202(a)(1). Alternatively, I discount Dr. Jarboe's and Naeye's allegation that the lesions are too small to be complicated and find that it is quite reasonable to expect, to a reasonable degree of certainty, that the sizes of the lesions yielded on biopsy are accurately depicted as at least "A" on X-ray, and are "massive" as that term is defined .30 U.S.C. §921(c)(3)(B); 718.304(b). The Claimant has complicated pneumoconiosis.

### **Onset**

On September 9, 1999, the Claimant filed for benefits under the Black Lung Benefits Act. Once a claimant proves entitlement to benefits, benefits should be paid commencing at the date of onset. 20 C.F.R. § 725.503. (b):

In the case of a miner who is totally disabled due to pneumoconiosis, benefits are payable to such miner beginning with the month of onset of total disability. Where the evidence does not establish the month of onset, benefits shall be payable to such miner beginning with the month during which the claim was filed, or the month during which the claimant elected review under Part 727 of this subchapter.

Where entitlement is established by operation of the irrebuttable presumption of total disability due to pneumoconiosis, 20 C.F.R. §718.304, I must determine whether the evidence establishes a specific onset date of claimant's complicated pneumoconiosis. *Williams v. Director, OWCP*, 13 BLR 1-28, 1-30 (1989). The miner cannot receive benefits for any month during which he or she was not entitled. *Lykins v. Director, OWCP*, 12 B.L.R. 1-181, 1-183 (1989).

The claimant bears the burden of proof in establishing the date of onset of total disability. See, e.g., *Johnson v. Director, OWCP*, 1 B.L.R. 1-600 (1978). In determining the onset date, the administrative law judge must consider all relevant evidence of record and assess the credibility of that evidence. *Lykins*, 12 B.L.R. at 1-183.

If the miner establishes that he has complicated pneumoconiosis according to 30 U.S.C. § 921(c)(3), the onset date is the month during which complicated pneumoconiosis was first diagnosed. *Truitt v. North American Coal Corp.*, 2 B.L.R. 1-199, 1-203 to 1-204 (1979). In *Truitt*, the Board held that the miner was entitled to benefits from the first month the evidence established that he suffered from complicated pneumoconiosis (in this case the earliest x-ray study

interpreted as positive for complicated pneumoconiosis), notwithstanding the fact that the study was interpreted as positive two years after it was taken. Moreover, it is noted that, in *Williams v. Director, OWCP*, 13 B.L.R. 1-28 (1989), the Board held that, "[i]f the evidence does not reflect when claimant's simple pneumoconiosis became complicated pneumoconiosis, the onset date for payment of benefits is the month during which the claim was filed or during which the claimant filed his election card, unless the evidence affirmatively establishes that claimant had only simple pneumoconiosis for any period subsequent to the date of filing or date of election." The Board noted, however, that the administrative law judge committed error when she did not consider a series of early chest x-rays which were interpreted as positive for the existence of complicated pneumoconiosis.

After a review of the entire record, I find that the Claimant has established that he had complicated pneumoconiosis as of June 12, 1998, when Dr. Westerfield read the May 21, 1998 X-ray. DX 11, DX 12. Subsequently, On June 19, the Claimant brought the May 21 X-ray to Dr. Baron, who also diagnosed pneumoconiosis. The Claimant told Dr. Baron that he was wheezing at night, but does not produce any cough or sputum. In September, the biopsy was performed that substantiates the X-ray reading.

### **ORDER**

**IT IS ORDERED** that the claim for benefits filed by JAMES H. PERRY is **granted**. The Employer, DEL RIO, INC shall:

1. Pay to the Claimant, all benefits to which he is entitled, including augmented benefits to his dependent, Dana Perry, under the Black Lung Benefits Act, commencing as of June 1, 1998 the month in which the Miner became entitled. (33 U.S.C. §§ 906(a); 20 C.F.R. § 725.503. (b).
2. Pay to the Secretary of Labor reimbursement for any payment the Secretary has made to JAMES H. PERRY under the Act, and to deduct such amounts, as appropriate, from the amount the Employer is ordered to pay under paragraph 1 above;
3. Pay to the Secretary of Labor interest as provided by law under Section 6621 of the Internal Revenue Code of 1954. Interest is to accrue thirty (30) days from the date of the initial determination of entitlement to benefits. 20 C.F.R. §§ 725.608.
4. Claimant's attorney is granted thirty (30) days to submit an application for fees conforming to the requirements of 20 C.F.R. §§ 725.365 and §§ 725.366.

**SO ORDERED.**

**A**

DANIEL F. SOLOMON  
Administrative Law Judge

**Notice of Appeal Rights:** Pursuant to 20 C.F.R. §725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date this decision is filed with the District Director, Office of Worker's Compensation Programs, by filing a notice of appeal with the Benefits Review Board, ATTN: Clerk of the Board, Post Office Box 37601, Washington, DC 20013-7601. See 20 C.F.R. §725.478 and §725.479. A copy of a notice

of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2605, 200 Constitution Avenue, NW, Washington, DC 20210.